Emory Ophthalmology / Pediatric Ophthalmology and Adult Strabismus
Patient Questionnaire

Patient Name: ______________________________ Date: ______________

Current Address: ______________________________

Current Phone: ______________________ Date of Birth: ______________

Who referred you to Emory?: ______________________________

Please answer all questions to the best of your ability and return the completed questionnaire to the technician or technologist when you are called.

Reason for Exam (explain): ______________________________

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General Health (check): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Past Medical History	Yes	No	Year of diagnosis	Details
Auto Immune Disease				
Infectious Disease				
Cancer				
Diabetes				
Blood Disorder				
Heart Disease				
Kidney Disease				
Skin Disease				
Neurologic Disorder				

OTHER ILLNESSES/SURGERY/or HOSPITALIZATION

Illness / Surgery / Hospitalization	Year	Details

History of Eye Infection, Injury or Surgery? ☐ No ☐ Yes

Describe briefly: ______________________________

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Family History:	Age	General Health	Eye Health
Patient's Father:			
Patient's Mother:			
Patient's Brothers:			
Patient's Sisters:			

Name: ______________________________ Date: ______________

CURRENT MEDICATIONS

Please list all medications you are currently taking, or check:

☐ No current medications

Medications	Amount Per Day	Reason

ALLERGIES

Allergies: Please list all the medications or substances to which you are allergic and specify the type of reaction or check:

☐ No known allergies

Allergies	Reaction

Social History:

Smoke: ☐ N/A (child) ☐ YES ☐ NO If yes, what is average number packs per day? ______________

Alcohol: ☐ N/A (child) ☐ YES ☐ NO If yes, what is average number drinks per day? ______________

Drugs: ☐ N/A (child) ☐ YES ☐ NO If yes, describe: ______________

Marital Status ☐ N/A (child): ______________

Employment or Grade Level in school: ______________

If the patient is a child, you must complete this section. If the patient is an adult, you may skip this section.

Parent's Name: ______________ Occupation: ______________

Parent's Name: ______________ Occupation: ______________

With whom does the patient live? ______________

WHO IS YOUR CHILD'S PEDIATRICIAN? Name: ______________

Address: ______________ Phone: ______________

Were there any problems with your child's gestation (pregnancy), delivery, or during the first 3 months of life?

☐ YES ☐ NO. If Yes, please describe: ______________

Has your child's growth and development been normal? ☐ YES ☐ NO. If No, please describe: ______________

REVIEW OF SYSTEMS: Please check YES or NO as deemed appropriate regarding the following symptoms. If you are not sure, leave blank.

NO	YES	GENERAL	Comment
☐	☐	Weakness	
☐	☐	Tiredness	
☐	☐	Early morning	
☐	☐	Late afternoon	
☐	☐	Lack of appetite	
☐	☐	Excess of appetite	
☐	☐	Weight loss	
☐	☐	Weight gain	
☐	☐	Chills	
☐	☐	Fever	
☐	☐	Night sweats	
☐	☐	Difficulty in sleeping	

NO	YES	EYES, EARS, NOSE, THROAT	Comment
☐	☐	Decreased ability to see	
☐	☐	Blurred vision	
☐	☐	Spots before your eyes	
☐	☐	Pain in the eyes	
☐	☐	Infection of the eyes	
☐	☐	Difficulty in hearing	
☐	☐	Pain in the ears	
☐	☐	Discharge from the ears	
☐	☐	Nosebleeds	
☐	☐	Running of the nose	
☐	☐	Sneezing	
☐	☐	Sinus trouble	
☐	☐	Hay Fever	
☐	☐	Sore throat	
☐	☐	Hoarseness	
☐	☐	Pain in the neck	
☐	☐	Dental trouble	
☐	☐	Bleeding gums	

NO	YES	RESPIRATORY	Comment
☐	☐	Dry cough	
☐	☐	Cough up phlegm	
☐	☐	Cough up blood	
☐	☐	Wheezing	
☐	☐	Asthma	
☐	☐	Shortness of breath at rest	
☐	☐	Shortness of breath with exertion	

NO	YES	CARDIOVASCULAR	Comment
❑	❑	Chest pain, tightness or squeezing	________
❑	❑	Shortness of breath lying down	________
❑	❑	Need to sit up to breathe	________
❑	❑	Heart racing	________
❑	❑	Irregular heart beat (palpitations)	________
❑	❑	Heart murmur	________
❑	❑	Swelling of the legs	________
❑	❑	Blue or purple discoloration of hand or feet	________

NO	YES	GASTROINTESTINAL	Comment
❑	❑	Nausea	________
❑	❑	Vomiting	________
❑	❑	Diarrhea	________
❑	❑	Constipation	________
❑	❑	Abdominal pain	________
❑	❑	Bright red blood in stools	________
❑	❑	Black stools	________
❑	❑	Change in bowel habits	________
❑	❑	Food intolerance	________

NO	YES	URINARY	Comment
❑	❑	Urinary tract infections	________
❑	❑	Pain or burning on urination	________
❑	❑	Frequent urination - day	________
❑	❑	Frequent urination - night	________
❑	❑	Unusually large volumes of urine	________
❑	❑	Kidney stones	________

NO	YES	MUSCULOSKELETAL	Comment
❑	❑	Painful joints	________
❑	❑	Swelling of any joints	________
❑	❑	Redness of any joints	________
❑	❑	Stiffness of any joints	________
❑	❑	Deformities of the joints extremities	________
❑	❑	Muscle pain	________
❑	❑	Back pain	________

NO	YES	ENDOCRINE	Comment
❑	❑	Goiter	________
❑	❑	Heat intolerance	________
❑	❑	Cold intolerance	________
❑	❑	Tremulousness of the hands	________
❑	❑	Change in pitch of the voice	________
❑	❑	Increased thirst	________
❑	❑	Increased urination	________
❑	❑	Marked increase in appetite	________

NO	YES	NEUROLOGIC/PSYCHIATRIC	Comment
❑	❑	Nervousness	
❑	❑	Depression	
❑	❑	Difficulty in going to sleep	
❑	❑	Early morning awakening	
❑	❑	Difficulty with memory for past events	
❑	❑	Difficulty with memory for recent events	
❑	❑	Difficulty with thinking or problem solving	
❑	❑	Headaches	
❑	❑	Blackouts	
❑	❑	Dizziness	
❑	❑	Double vision	
❑	❑	Paralysis or weakness of a limb(s)	
❑	❑	Loss of sensation	
❑	❑	Loss of balance	
❑	❑	Loss of coordination	
❑	❑	Difficulty in speaking	

		SKIN	
❑	❑	Dryness of skin	
❑	❑	Itching	
❑	❑	Rash	
❑	❑	Change in skin color	
❑	❑	Change in texture of the hair	
❑	❑	Falling out of the hair	
❑	❑	Nail changes	
❑	❑	Skin ulcers	

Reviewed by: ______________________

Date of Review: ______________________

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