Oakville Eye Care | Dr. Christine Yeung & Associates
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Pediatrics Questionnaire

Patient's Full Name: _____ Date of Birth: _____

OHIP: _____

Names of Parents: _____

Address: _____ Postal Code: _____

Home Phone Number: _____ Parents' Work Number _____

Emergency Contact (Name & Number): _____

Reason for Today's Appointment: _____

Date of child's last visual examination: _____

Date of child's last medical examination: _____

Doctor's name and address: _____

_____

_____

Child's Personal History:

Does your child have any complaints of blurred or double vision?	☐ Yes	☐ No
Does your child have an eye turn (strabismus)?	☐ Yes	☐ No
Has your child every had one eye patched to improve his/her other eye?	☐ Yes	☐ No
Have you, or your child's teachers, identified a reading problem?	☐ Yes	☐ No
Has your child ever been in hospital? *(If yes, please provide details)*	☐ Yes	☐ No
Has your child ever had eye surgery? *(If yes, please provide details)*	☐ Yes	☐ No
Has your child been registered as visually impaired or legally blind?	☐ Yes	☐ No
Is your child taking any medication? *(Please list)*	☐ Yes	☐ No
Does your child have any serious health-related problems since birth? *(If yes, please provide details)*	☐ Yes	☐ No
Does your child have any known allergies? *(If yes, please list)*	☐ Yes	☐ No
Is your child achieving expected developmental milestones for his/her age?	☐ Yes	☐ No
Are there any other relevant history or comments? *(If yes, please specify)*	☐ Yes	☐ No

Mother's Pregnancy

(Please check here if history is not known ☐)

Mother's general health during pregnancy: ☐ Good ☐ Fair ☐ Poor
Pregnancy was considered:
☐ Full-term
☐ Premature -- By how many weeks?
☐ Postmature -- By how many weeks?
Labor considered: Normal Difficult
Delivery was by: ☐ Forceps ☐ Caesarian ☐ Natural
Any serious eye or general health problems at birth? ☐ Yes ☐ No
(If yes, please specify)

Birth weight:

Family Eye History:

(Please check box if present or check here if history is not known ☐)

			Person with it (relationship to child)
Eye turn (strabismus)	☐ Yes	☐ No	
Ever had one eye patched	☐ Yes	☐ No	
Colour vision problems	☐ Yes	☐ No	
Eye shakes constantly (nystagmus)	☐ Yes	☐ No	
Glaucoma	☐ Yes	☐ No	
Eye-related surgery	☐ Yes	☐ No	
Poor vision or legal blindness	☐ Yes	☐ No	
Cataract	☐ Yes	☐ No	
Other *(please specify)*:	☐ Yes	☐ No	

Family General Health History:

(Please check box if present or check here if history is not known ☐)

			Person with it (relationship to child)
Allergies (medication)	☐ Yes	☐ No	
Allergies (other)	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
High blood pressure	☐ Yes	☐ No	
Low blood pressure	☐ Yes	☐ No	
Thyroid	☐ Yes	☐ No	
Epilepsy	☐ Yes	☐ No	
Stroke	☐ Yes	☐ No	
Heart problems	☐ Yes	☐ No	
Genetic syndromes *(please specify)*	☐ Yes	☐ No	

Other *(please specify)*: ☐ Yes ☐ No