235 S. Elliott Rd
Chapel Hill, NC 27514
P 919.968.4774 F 919.942.5291
Dr. Laurel Gropper & Dr. Scott Sikes

Pediatric Patient Parent Questionnaire

Name ________________________ **Nickname** ______________ **Birth Date** _____________

Height ________________ **Weight** ________________

School ________________ Grade____ Parents/Guardians' Names_______________________

Address ____________________________ City ______________ State ___ Zip Code_______

Reason for Visit:

____

Eye History

Is this your child's first exam? Y N If no, when was his/her last eye exam ________________

Please describe any previous eye or vision problems, including any treatment received

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Please check any of the following that you have noticed or that your child complains about:

__ blurred vision
__ double vision
__ closes or covers one eye to read
__ eye turns in, out, up or down
__ eyes tired during near work
__ loses place during reading
__ poor depth perception
__ squints or blinks excessively
__ tilts head
__ headache
__ eye strain
__ red or watery eyes
__ skips or re-reads lines
__ words run together while reading
__ poor hand-eye coordination

Educational History

Has your child repeated any grades_____________ if so, which ones?_____________

Does your child receive any special tutoring ______________________________________

Do you feel your child is performing up to their potential in school? Y N

Developmental History

Where there any complications with pregnancy or child birth? Y N if so, please describe

____

Was your child born prematurely? Y N If so, how soon?_________________________

Child's birth weight ____________ Apgar Score _____________

Did your child reach their developmental milestones on time? Y N

Was your child developmentally delayed? Y N

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Family Eye History	**Relation to child**
__ Strabismus (eye turn)	______________________
__ Amblyopia (lazy eye)	______________________
__ Glasses	______________________
__ Blindness	______________________

Medical History

Child's Pediatrician or Primary Care Provider____

Location ____ Phone #________________________

Please list any allergies to: Medication(s) _____________ Food ___________ Seasonal______

Please list any medication and/or supplements that your child is current taking

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Yes No Endocrine
- ☐ ☐ Diabetes ________________
- ☐ ☐ Thyroid _________________

Yes No Musculoskeletal
- ☐ ☐ JRA _____________

Yes No Respiratory
- ☐ ☐ Asthma_____

Yes No Cardiovascular
- ☐ ☐ Heart Disease ____________
- ☐ ☐ High Blood Pressure ______
- ☐ ☐ Arrhythmia ______________
- ☐ ☐ Anemia _________________

Yes No Psychiatric
- ☐ ☐ Depression ________
- ☐ ☐ ADD____________

Yes No Neurological
- ☐ ☐ Seizures ________________
- ☐ ☐ Headache ________________
- ☐ ☐ Cerebral Palsy____________

Yes No Skin
- ☐ ☐ Herpes Simplex_____
- ☐ ☐ Psoriasis__________
- ☐ ☐ Eczema___________

Yes No Gastrointestinal/Genitourinary
- ☐ ☐ Stomach/Intestine _________
- ☐ ☐ Genital _________________
- ☐ ☐ Kidney__________________
- ☐ ☐ Bladder _________________

Yes No Other Illnesses
- ☐ ☐ Cancer____________
- ☐ Other ________________________

Please list any surgery that has been performed on your child.