

## CHILDREN'S STRABISMUS QUESTIONNAIRE

**Please fill out this questionnaire carefully. Please return it to our office prior to your appointment in the envelope provided. **THANK YOU.****

Appointment: Day \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
Patient's Name: \_\_\_\_\_

### GENERAL INFORMATION

Were you referred to our office? Yes  No

If yes whom may we thank for this referral? \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Child's Full Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ years \_\_\_\_\_ months

Name and address of school: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_ School Nurse: \_\_\_\_\_ Principal: \_\_\_\_\_

Is your child especially afraid of doctors? \_\_\_\_\_

Child's dominant hand (circle): right or left? Has guidance been given in use of hand? Yes  No

Please list the names and birth dates of your family:

#### NAME

Father/Caretaker \_\_\_\_\_ Birth Date \_\_\_\_\_

Mother/Caretaker \_\_\_\_\_ Birth Date \_\_\_\_\_

Sibling \_\_\_\_\_ Birth Date \_\_\_\_\_

Sibling \_\_\_\_\_ Birth Date \_\_\_\_\_

Sibling \_\_\_\_\_ Birth Date \_\_\_\_\_

Sibling \_\_\_\_\_ Birth Date \_\_\_\_\_

### RESPONSIBLE PERSON INFORMATION

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Father / Caretaker's Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother / Caretaker's Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Do you have Major Medical Insurance? Yes  No

If so, who is the carrier? \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

### MEDICAL HISTORY

Pediatrician's Name: \_\_\_\_\_ Date of Last Evaluation: \_\_\_\_\_

For what reason? \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Child's current state of health: \_\_\_\_\_

Medications currently using, including vitamins and supplements: \_\_\_\_\_

Is there any history of the following? (please check if there is a history)

	<u>Patient</u>	<u>Family</u>	<u>Who</u>		<u>Patient</u>	<u>Family</u>	<u>Who</u>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>	_____	Chromosomal Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	_____

Any history in your family of an eye turn resulting from a disease or other condition? Yes  No

Other health problems? Yes  No

If yes, please explain: \_\_\_\_\_

Was there any related trauma, disease, or condition that preceded or accompanied the onset of the eye turn?

Yes  No

If yes, please explain: \_\_\_\_\_

Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes  No

If yes, please list: \_\_\_\_\_

List illnesses, bad falls, high fevers, etc.:

<u>Age</u>	<u>Severe</u>	<u>Mild</u>	<u>Complications</u>
_____	_____	_____	_____
_____	_____	_____	_____

Has a neurological evaluation been performed? Yes  No

By whom? \_\_\_\_\_ Results and recommendations: \_\_\_\_\_

Has a psychological evaluation been performed? Yes  No

By whom? \_\_\_\_\_ Results and recommendations: \_\_\_\_\_

Has an occupational therapy evaluation been performed? Yes  No

By whom? \_\_\_\_\_ Results and recommendations: \_\_\_\_\_

### DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes  No

Did the mother experience any problems during pregnancy? Yes  No

Normal birth? Yes  No

Were forceps used? Yes  No

Any complications before, during or immediately following delivery? Yes  No

Did your child crawl (stomach on floor)? Yes  No  At what age? \_\_\_\_\_

Did your child creep (stomach off floor)? Yes  No  At what age? \_\_\_\_\_

At what age did your child sit up (without support)? \_\_\_\_\_

At what age did your child walk (without support)? \_\_\_\_\_

First words: \_\_\_\_\_ At what age? \_\_\_\_\_

At what age did your child speak in a simple sentence (string two words together)? \_\_\_\_\_

Was your child alert as an infant? Yes  No

Were there ever any concerns regarding growth or development? Yes  No

If so, explain: \_\_\_\_\_

**NUTRITIONAL INFORMATION**

Current Diet: Excellent  Good  Fair  Poor

Does your child: Like sweets  or crave sweets

If yes, what types? \_\_\_\_\_

Are there any food allergies/sensitivities? Yes  No

If so, explain: \_\_\_\_\_

Is your child active? Yes  No  moderately  extremely

**VISUAL HISTORY**

At what age did you first notice or suspect that was an eye turning? \_\_\_\_\_

Did the eye begin turning - suddenly  or gradually

Does the eye turn - in  out  up  or down ? (check all that apply)

Is the eye turn getting worse or better, or is there no change? \_\_\_\_\_

Is it always the same eye that turns? Yes  No

If yes, which eye? Right  Left

Is the eye urn always present? Yes  No

If not, under what conditions is it present? (i.e. when tired, when ill, etc.) \_\_\_\_\_

Do you notice if the eye turns more when your child is looking:

up close? Yes  No

in the distance? Yes  No

to his/her left? Yes  No

to his/her right? Yes  No

up? Yes  No

down? Yes  No

Does one pupil ever appear to be larger than the other? Yes  No

Do you ever notice one or both eyes shaking rapidly? Yes  No

Does your child report any of the following:

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes "hurt" or "tired"	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motion sickness / car sickness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness of the eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____

List any other complaints your child makes concerning his/her vision: \_\_\_\_\_

Do you feel your child's vision hinders his/her daily activities in any way? Yes  No

If yes, how? \_\_\_\_\_

Have you or anyone else ever noticed the following:

	<u>Yes</u>	<u>No</u>	<u>If yes, when</u>
Eyes frequently reddened	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent eye rubbing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent sties	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frowning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bothered by light	<input type="checkbox"/>	<input type="checkbox"/>	_____
Closes or covers an eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty seeing distant objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head close to paper when writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Avoids/dislikes reading or other near tasks	<input type="checkbox"/>	<input type="checkbox"/>	_____

	<u>Yes</u>	<u>No</u>	<u>If yes, when</u>
Tilts head when reading or writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Moves head when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Confuses letters and words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reverses letters or words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Confuses right or left	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skips, omits words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loses place when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Uses finger as marker	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor reading comprehension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Comprehension decreases over time	<input type="checkbox"/>	<input type="checkbox"/>	_____
Writes or prints poorly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty copying form the chalkboard	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tires easily	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with short term memory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with long term memory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Short attention span/loses interest	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor / awkward large motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor / awkward fine motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dislikes/avoids sports	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty hitting / catching a ball	<input type="checkbox"/>	<input type="checkbox"/>	_____

**PREVIOUS TREATMENTS**

Has your child had a previous visual evaluation? Yes  No

Doctor's Name: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Were glasses, contact lenses, or other optical devices ever prescribed? Yes  No

If yes, Bifocal:  Single-vision:  Contact lenses:  Other:  Explain: \_\_\_\_\_

Are they used? Yes  No

If yes, when are they worn? \_\_\_\_\_

If no, why not? \_\_\_\_\_

Does the eye turn less when the prescription is worn? Yes  No  Unsure

Has there been any treatment using an eye patch? Yes  No

If yes, please describe when the patching was started, how the patching was done, including the age it started, the eye patched, the duration of treatment, and an estimate of the results: \_\_\_\_\_

\_\_\_\_\_

Have you ever been told that your child has amblyopia ("lazy eye")? Yes  No

Has there been any surgical treatment? Yes  No

If yes, please describe the surgery, including the age surgery was performed, the number of operations, the eye operated on, and an estimate of the cosmetic and subjective results: \_\_\_\_\_

Were you satisfied with the results of surgery? Yes  No

Please explain: \_\_\_\_\_

Was the surgeon satisfied with the results of surgery? Yes  No

Please explain: \_\_\_\_\_

Are you here for a second opinion regarding surgery or further treatment? Yes  No

Has there been any visual therapy? Yes  No

If yes, Drs. name: \_\_\_\_\_

If yes, please describe the type of visual therapy, including its duration, the age at which it started, and an estimate of the results: \_\_\_\_\_

**FAMILY AND HOME**

Please indicate which adult(s) he/she lives with? Mother  Father  Stepmother

Stepfather  Foster Parents  Adoptive Parents  Grandmother  Grandfather

Aunt  Uncle  Other Caretaker (please specify): \_\_\_\_\_

Does your child spend time with any other person, not in the home? Yes  No

Please explain: \_\_\_\_\_

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? Yes  No

If yes, at what age: \_\_\_\_\_

Does your child seem to have adjusted? Yes  No

Was counseling/therapy undertaken? Yes  No

If yes, is it on-going? Yes  No

Is family life stable at this time? Yes  No

If no, please explain: \_\_\_\_\_

**GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:** \_\_\_\_\_

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**IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL/IMPORTANT IN OUR TREATMENT OF YOUR CHILD?**

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**RELEASE OF INFORMATION AND INSURANCE FILING**

**It is often beneficial to us to discuss examination results and to exchange information with your child’s school, pediatrician, and/or other professionals involved in his/her care. Please sign below to authorize this exchange of information.**

I agree to permit information from, or copies of, my child’s examination records to be forwarded to other health care providers or insurance carriers upon their written request or upon the recommendation of the CLARENDON VISION DEVELOPMENT CENTER when it is necessary for the treatment of my child’s visual condition, or for the processing of insurance claims. I authorize CLARENDON VISION DEVELOPMENT CENTER to exchange information with my child’s school and other professionals involved in my child’s care by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

\_\_\_\_\_  
Parent’s or Guardian’s Signature

\_\_\_\_\_  
Date

I hereby give my permission to the CLARENDON VISION DEVELOPMENT CENTER to treat: \_\_\_\_\_  
(Child’s Name)

\_\_\_\_\_  
Parent’s or Guardian’s Signature

\_\_\_\_\_  
Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation of your child and to better meet your child’s specific visual needs

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us.

You may leave a message for us 24 hours a day / 7 days a week. We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your examination so that we will have the maximum opportunity to evaluate your child’s visual status.

Please do not bring any other children with you because your undivided attention is necessary during the evaluation.

THANK YOU.

Sincerely,

Monika Spokas, O.D., & Linda Weil O.D.