Vision Development Center
Guiding Vision Beyond 20/20

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CHILDREN'S STRABISMUS QUESTIONNAIRE

Please fill out this questionnaire carefully.
Please return it to our office prior to your appointment. 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
Father/ Caretaker Home Address:_____City_____Zip_____
Home Phone_____Cell Phone_____
Place of Employment & Position_____Work Phone_____
Email address: _____
Mother/ Caretaker Home Address:_____City_____Zip_____
Home Phone_____Cell Phone_____
Place of Employment & Position_____Work Phone_____
Email address: _____
Do you have Major Medical Insurance? Yes ☐ No ☐
If so, who is the carrier?_____Policy #_____
Name of Insured:_____

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:_____
_____
For what condition(s)? _____

Immunizations child has received:

Immunization type:_____Date:_____
Immunization type:_____Date:_____
Immunization type:_____Date:_____
Immunization type:_____Date:_____

Any reactions to immunization(s)? Yes ☐ No ☐

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

Age Severe Mild Complications

_____
_____
_____

Is your child generally healthy? Yes ☐ No ☐

If no, explain: _____

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

If yes, please list:_____

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: _____

_____

Any history in your family of any 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:_____

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

	Patient	**Family**	**Who**
Diabetes	☐	☐	_____
Thyroid Condition	☐	☐	_____
Brain tumor	☐	☐	_____
Cataracts	☐	☐	_____
Glaucoma	☐	☐	_____
High Blood Pressure	☐	☐	_____
Chromosomal Imbalance	☐	☐	_____
Learning Disability	☐	☐	_____
Amblyopia (lazy eye)	☐	☐	_____
Multiple Sclerosis	☐	☐	_____
Blindness	☐	☐	_____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes ☐ No ☐
Did 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 ☐ If yes, moderately ☐ or extremely ☐

VISUAL HISTORY

At what age did you first notice or suspect that an eye was 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 turn 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:

	Yes	No	If yes, when?
Headaches	☐	☐	_____
Blurred vision	☐	☐	_____
Double vision	☐	☐	_____
Eyes “hurt” or “tired”	☐	☐	_____
Motion sickness / car sickness	☐	☐	_____
Redness of the eyes	☐	☐	_____

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:

	Yes	No	If yes, when?
Eyes frequently reddened	☐	☐	_____
Frequent eye rubbing	☐	☐	_____
Frequent sties	☐	☐	_____
Frowning	☐	☐	_____
Bothered by light	☐	☐	_____
Closes or covers an eye	☐	☐	_____
Difficulty seeing distant objects	☐	☐	_____
Head close to paper when writing	☐	☐	_____
Tilts head when reading or writing	☐	☐	_____
Moves head when reading	☐	☐	_____
Confuses letters/words/numbers	☐	☐	_____
Reverses letters/words/numbers	☐	☐	_____
Misaligns digits or columns of numbers	☐	☐	_____
Confuses right or left	☐	☐	_____
Skips, omits words	☐	☐	_____
Loses place when reading	☐	☐	_____
Uses finger as marker	☐	☐	_____
Poor reading comprehension	☐	☐	_____
Comprehension decreases over time	☐	☐	_____
Writes or prints poorly	☐	☐	_____
Difficulty copying from the chalkboard	☐	☐	_____
Tires easily	☐	☐	_____
Poor organizational skills	☐	☐	_____
Difficulty with short term memory	☐	☐	_____
Difficulty with long term memory	☐	☐	_____
Short attention span/loses interest	☐	☐	_____
Poor / awkward large motor coordination	☐	☐	_____
Poor / awkward fine motor coordination	☐	☐	_____
Dislikes / avoids sports	☐	☐	_____
Judges distances accurately	☐	☐	_____
Difficulty hitting / catching a ball	☐	☐	_____

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: _____

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Does child watch TV? _____ How much? _____ How often? _____ Viewing Distance? _____
Does your child spend time using computer/video games? Yes ☐ No ☐
If yes, how much? _____ How often? _____ Viewing distance? _____
What other activities occupy your child's leisure time? _____
Are there any activities your child would like to participate in, but doesn't? _____
Please explain: _____
_____

SCHOOL

Age at time of entrance to: Pre-school _____ Kindergarten _____ First Grade _____
Does your child like school? Yes ☐ No ☐
Specifically describe any school difficulties: _____
_____
Has your child changed schools often? Yes ☐ No ☐
If yes, when? _____
Has a grade been repeated? Yes ☐ No ☐
If yes, which and why? _____
Does your child seem to be under tension or extreme pressure when doing school work? Yes ☐ No ☐
Has your child had any special tutoring, therapy, and/or remedial assistance? Yes ☐ No ☐
If yes, when? _____
Where and from whom? _____
How long? _____
Results: _____
Does your child like to read? Yes ☐ No ☐
Voluntarily? Yes ☐ No ☐
Does your child read for pleasure? Yes ☐ No ☐
What? _____
What is your child's attitude toward reading, school, his/her teachers, other youngsters? _____
_____
Overall schoolwork is: above average ☐ average ☐ below average ☐
WHICH SUBJECTS ARE:
Above average: _____
Average: _____
Below average: _____
Does your child need to spend a lot of time/effort to maintain this level of performance? Yes ☐ No ☐
How much time on average does your child spend each day on homework assignments? _____
To what extent do you assist your child with homework? _____
Do you feel your child is achieving up to potential? Yes ☐ No ☐
Does the teacher feel your child is achieving up to potential? Yes ☐ No ☐

GENERAL BEHAVIOR

Are there any behavior problems at school? Yes ☐ No ☐
If yes, what? _____
Are there any behavior problems at home? Yes ☐ No ☐
If yes, what? _____
What causes these problems? _____
Child's reaction to fatigue? lethargic ☐ irritable ☐ other ☐
Child's reaction to tension? avoidance ☐ irritable ☐ other ☐
Does your child say and/or do things impulsively? Yes ☐ No ☐
Is your child in constant motion? Yes ☐ No ☐
Can your child sit still for long periods? Yes ☐ No ☐

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: _____

Please give a brief description of your child as a person:

_____

_____

_____

_____

_____

_____

Is there any other information that would be important/useful in our treatment of your child?

_____

_____

_____

_____