SAN DIEGO CENTER for VISION CARE-

Optometry, P.C.
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CHILDREN'S STRABISMUS AND AMBLYOPIA QUESTIONNAIRE

Please fill out this questionnaire carefully. Please return it to our office prior to your appointment.

Appointment: Day _____ Date _____ Time _____
Patient's Name: _____

GENERAL INFORMATION

Were you referred? Yes _____ No _____

If yes, by whom? _____ Phone: _____

Address:

_____

Your child's Full Name: _____
Male _____ Female _____
Birth Date: _____ Age: _____ years _____ months
Name and address of school:

_____

Grade _____ Teacher _____ School Nurse _____ Principal _____
Is your child especially afraid of doctors? _____
Your child's handedness: right or left? _____

HOME:Guardian/Father _____ Birth Date _____
Mother/Guardian _____ Birth Date _____
Siblings _____ Birth Date _____
_____ Birth Date _____
_____ Birth Date _____
_____ Birth Date _____

PARENT INFORMATION

Home Address _____ City _____ Zip _____
Home Phone _____
Father's Occupation _____ Business Phone _____
Business Address _____ Father's Cell Phone _____
Father's Email Address _____ City _____ Zip _____
Mother's Occupation _____ Business Phone _____
Business Address _____ Mother's Cell Phone _____
Mother's Email Address _____ City _____ Zip _____

Do you have Major Medical Insurance? _____ Policy # _____

If so, who is the carrier? _____

Name of Insured: _____

Social Security Number _____ Driver's License No. _____

Please continue on the other side

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Results _____

Medications currently using

_____

For what condition? _____

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

	Patient	Family		Patient	Family
High Blood Pressure	_____	_____	Glaucoma	_____	_____
Diabetes	_____	_____	Cataract	_____	_____
Thyroid Condition	_____	_____	Blindness	_____	_____
Multiple Sclerosis	_____	_____	Strabismus	_____	_____
Brain Tumor	_____	_____	Amblyopia	_____	_____
Chromosomal Imbalance	_____	_____	Macular Degeneration	_____	_____

Any history in your family of an eyeturn resulting from a disease or other condition? ..Yes _____ No _____

_____

Other health problems? .....Yes _____ No _____

If yes, please explain _____

Is there any related trauma, disease, or condition with your child that preceded or accompanied the onset of the eyeturn? .....Yes _____ No _____

If yes, please explain _____

Has your child been prone to infections? .....Yes _____ No _____

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

If yes, please list _____

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

Age Severe Mild Complications

_____

_____

_____

Has a neurological evaluation been performed? .....Yes _____ No _____

By whom? _____ Results _____

Has a psychological evaluation been performed? .....Yes _____ No _____

By whom? _____ Results _____

DEVELOPMENTAL HISTORY

Full-term 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)? _____
At what age did your child talk (string two words together)? _____
Was your child alert as an infant? ..... Yes _____ No _____

NUTRITIONAL INFORMATION

Current Diet: Excellent _____ Good _____ Fair _____ Poor _____
Does your child:
like sweets ..... Yes _____ No _____
crave sweets ..... Yes _____ No _____
Is your child active? ..... Yes _____ No _____
moderately? ..... Yes _____ No _____
extremely? ..... Yes _____ No _____

VISUAL HISTORY

If you ever suspected the eye to be turning, at what age did you first notice it? _____
If you ever saw an eye turn, did the eye begin turning suddenly or gradually?
_____
If you ever saw an eye turn, does the eye turn in, out, up, or down?
_____
If one eye does turn in a different direction, is the eye turn getting worse or better, or is there no change? _____
If one eye does turn in a different direction, is it always the same eye that turns? ..... Yes _____ No _____
If yes, which eye? _____
If one eye does turn in a different direction, is the eye turn always present? ..... Yes _____ No _____
If not, under what condition is it present? _____
If one eye does turn in a different direction, 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	_____	_____	_____

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?

_____

_____

_____

PREVIOUS TREATMENTS

Doctor's Name _____ Date of Last Visit _____

Results _____

Were glasses or contact lenses ever prescribed?.....Yes _____ No _____

If yes, bifocal _____ single-vision _____ Date _____

Are they worn?.....Yes _____ No _____

When are they worn? _____

If an eye does turn, does the eye turn less when the prescription is worn? Yes _____

No _____

PREVIOUS TREATMENTS (continued)

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: _____

_____

_____

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: _____

_____

_____

Has there been any visual therapy?.....Yes _____ No _____

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 he/she lives with?

Mother _____ Father _____ Stepmother ____ Stepfather _____ Foster Parents _____

Adoptive Parents ___ Grandmother _____ Grandfather _____ Aunt _____ Uncle _____ Other _____

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

What age was (s)he? _____

Does your child seem to have adjusted?.....Yes _____ No _____

Is family life stable at this time?.....Yes _____ No _____

RELEASE OF INFORMATION AND INSURANCE FILING

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 San Diego Center for Vision Care - Optometry - P.C. when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I release payment of benefits to myself or to the San Diego Center for Vision Care - Optometry - P.C.

If records or reports are requested by my child's school district, I authorize their release.

_____ _____

Signature Date

I hereby give my permission to the San Diego Center for Vision Care - Optometry - P.C. 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 relate the current visual skills to any specific needs.
Please be on time for your examination.
Thank you.

The Doctors And Staff
San Diego Center for Vision Care - Optometry - P.C.