Optometry,P.C.

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ADULT STRABISMUS/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

Full Name: ______________________________________ Male _____ Female _____

Birth Date: ______________________ Age: _____

Address: ____

Telephone Number (home) ______________________________ (work) ____________________

Were you referred? Yes _____ No _____

If yes, by whom? ____________________________ Phone: ____________________

Address: ____

Do you have major medical insurance? ______________ Do you have a flex spending account? Y N

If yes, who is the carrier? ______________________ Policy # ______________________

Name of Insured ______________________________

Social Security Number ______________________ Driver's License No.____________________

Does your insurance cover eye examinations or eyeglasses? Yes _____ No _____

What is your occupation? ____

Employer ______________________________ Work Phone __________________________

Business Address ____

Spouse's Name ______________________________Occupation ____________________

Spouse's Employer ______________________________ Work Phone____________________

Business Address ____

MEDICAL HISTORY

Physician's Name ______________________________ Date of Last Visit

____

Results ____

Medications currently using:

____

For what condition? ____

Please continue on the other side

MEDICAL HISTORY (continued)

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

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

Do you use cigarettes/tobacco? ....Yes ______ No ______
Do you drink alcohol?..Yes ______ No ______
Do you use other substances? ....Yes ______ No ______
Any history in your family of an eye turn resulting from a disease/other condition?....Yes ______ No ______

____
Other health problems? ....Yes ______ No ______
If yes, please explain ____
Is there any related trauma, disease, or condition that preceded or accompanied the onset of the eye turn?..Yes ______ No ______
If yes, please explain ____
Are you 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 ______

NUTRITIONAL INFORMATION

Current Diet: Excellent ________ Good ________ Fair ________ Poor ________
Do you: like sweets ....Yes ______ No ______
crave sweets ....Yes ______ No ______
Are there any indications that you have been exposed to any toxic
substances or fumes? ....Yes ______ No ______

VISUAL HISTORY

At what age, if at all, did you first suspect that an eye was turning? ______________________________________
If one eye does turn in a different direction, did the eye begin turning suddenly or gradually? ______________
If one eye does turn in a different direction, 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 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 you look:

up close? ....Yes ______ No ______

in the distance? ....Yes ______ No ______

to your left? ....Yes ______ No ______

to your 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 ______

Do you experience 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 you have concerning your vision: ____

____

____

Do you feel your vision hinders your 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 ______

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: ___________

____

____

PREVIOUS TREATMENTS (continued)

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: ____

____

____

EMPLOYMENT OR SCHOOL

Current position ________________________________ Major course of study ________________________

How many hours daily do you spend at a desk? _______ Computer? ____________________________________

How many hours daily do you spend reading or studying? ___________

How many hours daily do you spend working at near distances? ___________

Are you achieving to your potential in work or school? ....Yes ______ No ______

Do you feel you are getting adequate return for the amount of effort you put into a task?...Yes ______ No ______

Does your work or course of study demand comprehension from the written word? Yes ______ No ______

Describe briefly your daily activities at work or in school: ____

____

____

HOBBIES

Describe the types of activities that comprise the majority of your spare time: ___________________________

____

____

Do you watch TV? Yes ______ No ______

If yes, how many hours per day? ___________

How many days per week? ___________

Are you seriously involved with athletics? Yes ______ No ______

Do you feel you are achieving up to your potential? Yes ______ No ______

Of all the sports you have played:

List the ones in which you excel: ____

List the ones in which you do poorly: ____

RELEASE OF INFORMATION AND INSURANCE FILING

I agree to permit information from, or copies of, my 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 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.

____ ____________________________________

Signature or Authorized Representative 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.