OPTOMETRY, P.C.

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# STRABISMUS/AMBLYOPIA QUESTIONNAIRE (Adult)

***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: ________________________________________________________________

Full Name: ____________________________________________ Nickname ____________________

Male ____ Female ____ Birth Date: ______________________________ Age: ______ years _____ months

Home Address ______________________________________ City ____________________ Zip__________

Home Phone______________________________________ Cell Phone ____________________

Occupation______________________________________ Email Address ____________________

Spouse's Name ______________________________________ Occupation ____________________

Do you have Major Medical Insurance? ____________________ Do you have a flex spending account? Y N

If so, who is the carrier? ______________________________ Policy # ____________________

Name of Insured: ________________________________________________________________

Social Security Number (last 4 #'s) ____________________ Driver's License No. ____________________

## MEDICAL HISTORY

Physician's Name __________________________________ Date of Last Visit ____________________

Result ________________________________________________________________

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 | ______ | ______ | Stroke | ______ | ______ |

**MEDICAL HISTORY (continued)**

Do you use tobacco? ........ Yes ______ No ______

Do you drink alcohol? ........ Yes ______ No ______

Do you use other substances? ........ Yes ______ No ______

Any history in your family of eye misalignment resulting from a disease/other condition? ... Yes ______ No ______

________________________________________________________________

Are there other health problems? ........ Yes ______ No ______

If yes, please explain ________________________________________________

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

If yes, please list ________________________________________________

Current Diet: Excellent ________ Good ________ Fair ________ Poor ________

Has there been exposure to toxic mold, substances or fumes? ........ Yes ______ No ______

List illnesses, concussions, head or brain injuries, bad falls, high fevers, ear infections, etc.:

| Age | Severe | Mild | Complications |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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

By whom? ____________________ Results ________________________________

**PREVIOUS VISUAL EXAMINATIONS**

Have you had a previous vision examination? ........ Yes ______ No ______

If yes, doctor's name: ________________________________________________

Date of last visit: ________________________________________________

Reason for examination: ________________________________________________

Results: ________________________________________________

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

If yes, Bifocal? __________ Single-vision? __________ Date Prescribed ______________

Are they worn? ........ Yes ______ No ______

When are they worn? ________________________________________________

Are they for distance? ........ Yes ______ No ______

Are they for near? ........ Yes ______ No ______

Are they for full-time use? ........ Yes ______ No ______

Were contact lenses ever prescribed? ........ Yes ______ No ______

If you wear contact lenses, how long have you worn them? ______________________________

Have you been told you could not wear contact lenses? ........ Yes ______ No ______

If you do not wear contact lenses, are there times you would benefit from them? ........ Yes ______ No ______

Sports: ........ Yes ______ No ______

Social Events: ........ Yes ______ No ______

Appearance: ........ Yes ______ No ______

If you were prescribed contact lenses, have you stopped wearing them? ........ Yes ______ No ______

If yes, why did you stop? ________________________________________________

Have you had refractive surgery? ........ Yes ______ No ______

Members of the family who have had visual attention and the reason:

| Name | Age | Visual Situation |
| --- | --- | --- |
| ______________________________ | ______ | __________________________________________________ |
| ______________________________ | ______ | __________________________________________________ |

**STRABISMUS AND AMBLYOPIA**

If an eye is out of alignment, is it 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 functional result: __________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

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 the results: _________________________________________________________________________________

_____________________________________________________________________________________________

At what age, if at all, did you first suspect that an eye was turning? ________________________________________

Is there any related trauma, disease, or condition that preceded or accompanied the onset of the eye misalignment? ........................................................................................ Yes ______ No ______

If yes, please explain ______________________________________________________________________

Do you tilt or turn your head in order to see more comfortably? ................................. Yes ______ No ______

Do you have any neck or back pain or restrictions? ................................................ Yes ______ No ______

If one eye does turn in a different direction than the other:

did it turn suddenly or gradually? _____________________________________________________________

does it turn in, out, up, or down? _____________________________________________________________

is the eye turn getting worse or better, or no change? ____________________________________________

is it always the same eye that turns? ....................................................... Yes ______ No ______

If yes, which eye? __________________________________________________________________

is the eye turn always present? ............................................................ Yes ______ No ______

If not, under what condition is it present? ______________________________________________

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 | _____ | _____ | ________________________________ |
| Dizziness | _____ | _____ | ________________________________ |
| Shaking of your visual field | _____ | _____ | ________________________________ |
| Squinting or closing one eye | _____ | _____ | ________________________________ |

List any other concerns you have regarding your vision: ____________________________________________

________________________________________________________________________________

________________________________________________________________________________

In what way is your vision hindering your daily activities? ____________________________________________

________________________________________________________________________________

________________________________________________________________________________

**"SCREEN TIME"**

This is the amount of time you look at a TV, computer, iPad or tablet, "Smart Phone", Kindle, etc.

| | | | |
|---|---|---|---|
| Academic/Work: | Days per week_______ | Hours per day____ | Distance from eyes to screen_______ |
| Recreational: | Days per week_______ | Hours per day____ | Distance from eyes to screen_______ |
| Social/texting: | Days per week_______ | Hours per day____ | Distance from eyes to screen_______ |

Do you access social or recreational screen time while working or studying? Yes _____ No _____

What are the total hours you are in front of a screen? Hours per day _____

Is there visual or physical discomfort with computer use? Yes _____ No _____

**COMPUTERS**

Where is the computer screen located?

- ☐ Directly in front of you when seated
- ☐ To your right
- ☐ To your left

Where is the top of the screen located?

- ☐ Above your straight-ahead eye level
- ☐ At eye level
- ☐ Below eye level

Where are your source documents located?

- ☐ Directly in front of you when seated
- ☐ To your right
- ☐ To your left
- ☐ Flat (horizontal) or vertical

Do you experience any of the following lighting problems in your work area?

- ☐ glare from windows or other light sources
- ☐ reflections on your computer screen
- ☐ difficulty reading source documents

Do you wear glasses or contact lenses for computer work?

- ☐ glasses
- ☐ contact lenses

**EMPLOYMENT OR SCHOOL**

Current position ___________________________________ Major course of study ________________________________

How many hours daily do you spend at a desk? __________

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 ______

Are you getting adequate return for the amount of effort you put into a task? ................ 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: ________________________________

____________________________________________________________________________________________________

Are you seriously involved with athletics? .......................................................... Yes ______ No ______

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

Of all the sports you have played:

List the ones in which you excel: ___________________________________________________________________

List the ones in which you do not excel: _____________________________________________________________

What are your visual goals?

I hereby give my permission to the San Diego Center for Vision Care – Optometry, P.C. to treat

_________________________________________________________.

(Name)

_________________________________________________________ ________________________________________

Signature Date

Would you be interested in online telemedicine consultations or conferences in the future?

Yes ____ No ____ Maybe ____

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.**