OPTOMETRY, P.C.

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STRABISMUS/AMBLYOPIA QUESTIONNAIRE (Child)

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: ____

Child's Full Name: ____ Nickname ________________________

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

Name and address of school: ____

Grade ____ Teacher ______________________________ Principal ______________________________

Is your child especially afraid of doctors? Yes or No (please circle) Child's handedness: Right or Left (please circle)

HOME: Father/Guardian __________________________ Birth Date ________________________

Mother/Guardian __________________________ Birth Date ________________________

Sibling(s) __________________________ Birth Date ________________________

__________________________ Birth Date ________________________

__________________________ Birth Date ________________________

PARENT INFORMATION

Please Circle: ***Mother Father Both Other*** ____

Home Address ____ City ______________________ Zip__________

Home Phone____ Cell Phone ____________________________

Occupation____ Email Address __________________________

Please Circle: ***Mother Father Both Other*** ____

Home Address ____ City ______________________ Zip__________

Home Phone____ Cell Phone ____________________________

Occupation____ Email Address __________________________

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 ______________

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	______	______
Stroke	______	______	Chromosomal Imbalance	______	______

Other ______________________

Any family history of poor eye-alignment resulting from disease or other conditions?........... Yes _____ No _____

____

Are there other health problems with your child? .... Yes _____ No _____

If yes, please explain ______________________

Is there any related trauma, disease, or condition that your child experienced preceding or accompanying the onset of the eye-alignment difficulty?.. Yes _____ No _____

If yes, please explain ______________________

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

Age	Severe	Mild	Complications

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

If yes, by whom? ______________________ Date ______________

Results ______________________

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

If yes, by whom? ______________________ Date ______________

Results ______________________

Has a speech and language evaluation been performed?... Yes _____ No _____

If yes, by whom? ______________________ Date ______________

Results ______________________

Has an occupational therapy evaluation been performed?... Yes _____ No _____

If yes, by whom? ______________________ Date ______________

Results ______________________

Has a physical therapy evaluation been performed? .... Yes _____ No _____

If yes, by whom? ______________________ Date ______________

Results ______________________

Are there any other evaluations that have been performed? .... Yes _____ No _____

If yes, by whom? ______________________ Date ______________

Results ______________________

PREVIOUS VISION EXAMINATIONS

Has your child 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 ______

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? ______________________

Does your child tilt or turn their head in order to see more comfortably? .... Yes ______ No ______

Does your child 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 your child looks:

up close? .... Yes ______ No ______

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

to their left? .... Yes ______ No ______

to their 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 experience any of the following?:	Yes	No	If yes, when?
Headaches	_____	_____	______________________________
Blurred vision	_____	_____	______________________________
Double vision	_____	_____	______________________________
Eyes “feel tired”, “ache” or “hurt”	_____	_____	______________________________
They fatigue easily	_____	_____	______________________________
Brightness is bothersome	_____	_____	______________________________
Fluorescent lights are bothersome	_____	_____	______________________________
Patterned wallpaper or carpets are bothersome	_____	_____	______________________________
Grocery stores or malls are difficult to be in	_____	_____	______________________________
Movement of objects in the environment is bothersome or distracting	_____	_____	______________________________
There is difficulty with peripheral vision	_____	_____	______________________________
One eye turns in, out, up or down	_____	_____	______________________________
Squinting, covering or closing one of their eyes	_____	_____	______________________________
Frequently blinking	_____	_____	______________________________
Frequently rubbing eyes	_____	_____	______________________________
Frequently reddened eyes	_____	_____	______________________________
Eyes itch	_____	_____	______________________________
Excess mucus or tears	_____	_____	______________________________
Motion sickness or dizziness (circle one or both)	_____	_____	______________________________
Uncomfortable watching 3-D movies	_____	_____	______________________________
They dislike heights	_____	_____	______________________________
Difficulty catching or hitting a ball	_____	_____	______________________________
Poor motor or balance coordination	_____	_____	______________________________
Difficulty using both sides of the body together	_____	_____	______________________________
Delayed dressing skills	_____	_____	______________________________
Moving their head close to paper when reading or writing	_____	_____	______________________________
Tilting their head when reading or writing	_____	_____	______________________________
Their head moves when reading	_____	_____	______________________________
Confusing letters or words (circle one or both)	_____	_____	______________________________
Reversing letters or words (circle one or both)	_____	_____	______________________________
Words appear to move around on the page	_____	_____	______________________________
Skipping, rereading or omitting words (circle)	_____	_____	______________________________
They lose their place while reading	_____	_____	______________________________
They use their finger as a marker when reading	_____	_____	______________________________
Vocalizing when they are reading silently	_____	_____	______________________________
Reading slowly	_____	_____	______________________________
Poor reading comprehension	_____	_____	______________________________

HAVE YOU EVER NOTICED THE FOLLOWING?:

	Yes	No	If yes, when?
There are memory difficulties	_____	_____	_______________
Difficulty following a series of directions	_____	_____	_______________
Short attention span when reading or writing	_____	_____	_______________
Poor spelling	_____	_____	_______________
Writing or printing poorly	_____	_____	_______________
They orient drawings poorly on the page	_____	_____	_______________
Difficulty copying from the board at school	_____	_____	_______________
Difficulty completing their assignments	_____	_____	_______________
Avoiding activities that are within arm's reach (e.g. legos)	_____	_____	_______________

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

____

Does their vision interfere with activities of daily living? .... Yes _____ No _____

If yes, please explain: ____

____

NUTRITIONAL INFORMATION

Current Diet: Varied ________ Picky? ________ Supplements ________ Food allergies ________

Does your child:

like sweets .... Yes _____ No ______

crave sweets .... Yes _____ No ______

Is your child active? .... Yes _____ No ______

moderately? .... Yes _____ No ______

extremely? .... Yes _____ No ______

Are there periods of very high energy? .... Yes _____ No ______

very low energy? .... Yes _____ No ______

DEVELOPMENTAL HISTORY

Full-term pregnancy? .... Yes _____ No _____

Normal birth? .... Yes _____ No _____

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

If yes, please explain ____

Did your child crawl (stomach on floor)? Yes ______ No ______ At What Age? ________________

Did your child creep (stomach off floor)? Yes ______ No ______ At What Age? ________________

If not, describe ____

At what age did your child walk? ____________________ Was your child active? .... Yes _____ No _____

Speech: First words at age ____________________ Was your child alert as an infant? .... Yes _____ No _____

Was early speech clear to others? Yes ______ No ______ Is it clear now? .... Yes _____ No _____

"SCREEN TIME"

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

Academic time: 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_______

Does your child have access to recreational or social "screen time" while doing homework? Yes _____ No _____

What are the total hours your child is in front of a screen? Hours per day____

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

FAMILY AND HOME

Please indicate which adult(s) your child 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 ______

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

PURPOSE OF EVALUATION? WHAT YOU HOPE TO LEARN FROM EVALUATION?:

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

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.