Adult Amblyopia & Strabismus Questionnaire

Please fill out this questionnaire **carefully**. Thank you!

Name _____Age _____ Birth date _____

Email _____ Occupation _____

Whom may we thank for referring you?_____

Main concern/reason for visit_____

_____

MEDICAL HISTORY

Date of most recent medical exam _____Doctor's name_____

List any medications_____

List illnesses, bad falls, head injuries, car accidents etc._____

List any chronic problems _____

Has a *neurological* and/or *psychological* evaluation been performed (please circle)?

Any current or past *Occupational, Physica*l and/or *Speech* Therapy (please circle)?

VISUAL HISTORY

Date of last eye exam_____ Name of optometrist _____

Results & recommendations: _____

Date of last dilated eye exam (eye drops to enlarge the pupils)_____

Were glasses prescribed from last eye exam? Y N Did you fill the prescription? Y N

How many pairs of glasses do you currently wear on a regular basis? _____

What type? □ Progressive Glasses □ Bifocal Glasses □ Single vision glasses for full time wear

□ Single vision glasses for driving □ Single vision glasses for reading books/computer

Do you wear prisms in your current glasses? Y N Have you worn prism glasses previously? Y N

Have you ever been told you have a lazy eye? Y N

If you had treatment requiring an eye patch, how often and for long was it done? _____

Are you being monitored by an ophthalmologist/ eye surgeon? Who? _____

Results and recommendations by ophthalmologist?_____

Date(s) of past eye muscle surgeries, if any? _____

- After how long after your last eye surgery did the eye begin turning again? _____

Which eye is turning?___ _____ Does the eye turn: in, out, up or down ?

At what age did the eye turn start? _____ Did the eye begin turning suddenly or gradually?

What percentage of waking hours does the eye turn? _____

Is the eye turn worse when looking (please circle) at near or distance? To the right, left, up or down?

Do you have double vision? If yes, please answer the questions below.

- When did it start?_____
- Is the double image: side by side, diagonal, up and down or it varies in direction?
- Is the double vision occurring at near, distance or both?
- When does it occur? Morning, night, driving, reading, computer, all day?
- Does the double image disappear if you close one eye?
- Does your glasses help eliminate your double vision if any? Y N

Any other visual conditions (previous eye injuries, glaucoma, macular degeneration)_____

_____

SYMPTOM SURVEY

Please assign a **value** between 0 and 3 for each symptom (0 = symptom not present; 1 = symptom minimally present; 2 = symptom moderately present; 3= symptom severely present)

__ Blurred vision, distance viewing
__ Blurred vision, near viewing
__ Slow to shift focus, near to far to near
__ Discomfort when reading
__ Falling asleep when reading
__ Vision worse at the end of the day
__ Difficulty moving or turning eyes
__ Pain with movement of the eyes
__ Pain in or around eyes
__ Pulling or tugging sensation around the eyes
__ Headaches
__ Wandering eye
__ Face or head turn
__ Head Tilt
__ Covering, closing one eye
__ Words run together when reading
__ Poor ability to remember what is read
__ Skipping words/lines when reading
__ Avoiding sports and games
__ Inability to estimate distances accurately
__ Poor Posture
__ Loss of Balance