Child Amblyopia & Strabismus Questionnaire

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

Child's Name _____ Age _____ D.O.B. _____

Whom may we thank for referring you?_____

Names of Parents or Legal Guardians_____

Parents or Guardians' Occupation _____

Email Address _____

Main concern/Reason for visit_____

MEDICAL HISTORY

Date of most recent medical exam_____ Doctor's name_____

List any long term medications _____

List any head injuries, illness and any chronic problems _____

_____

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

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

Is there any history of the following?

	Child	Family		Child	Family		Child	Family
Eye Turn(Strabismus)	☐	☐	Lazy Eye(Amblyopia)	☐	☐	High Prescription	☐	☐
Learning Disabilities	☐	☐	Eye Shake(Nystagmus)	☐	☐	ADD/ADHD	☐	☐
Autism	☐	☐						

DEVELOPMENTAL HISTORY

Period of Pregnancy (weeks) _____ Peri-natal Complications_____

Age when child first: Sit_____ Crawl_____ Walk _____ Talk_____

Is your child performing below, above or at grade level for knowing numbers/letters, writing and reading?

_____

List any past or current tutoring, Early Childhood Services and/or Individualized Program Planning (IPP)?

_____

VISUAL HISTORY

Date of last eye exam_____ Name of optometrist _____

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

Age when your child received the first pair of glasses _____ Age of current glasses _____

Are they worn full time or part time (please circle)? For near or distance or both?

Are there prisms in your child's current glasses? Y N Has your child worn prism glasses previously? Y N

Have you ever been told your child has a lazy eye? Y N

If your child has worn an eye patch, how many hours/day_____ times/week _____ , and for a total of how many months_____?

What activities were performed while patching? _____

EYE TURN HISTORY

Is your child seeing an eye surgeon/ophthalmologist? Who? _____

Results and recommendations by ophthalmologist?_____

Has your child had eye muscle surgeries? If yes, when? _____

- After how long after the 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?

Is the eye turn getting worse or better, no change since initial onset? _____

What percentage of waking hours does the eye turn? _____

Is the eye turn worse when looking (please circle) at near or distance?

Is the eye turn worse when looking (please circle) to the right, left, up or down?

Does one pupil ever appear to be larger than the other? Y N

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)

__ Bumping into objects/clumsy
__ Headaches around the eyes/forehead
__ Holding reading material too close
__ Trouble catching a ball
__ Avoidance/poor focus with near work/reading
__ Head turn or tilt when looking at something
__ Skipping of words when reading
__ Slow at copying from the board at school