5151 Bluebonnet Blvd.
Baton Rouge, LA 70809
Phone: (225) 769-6010
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Lafayette, LA 70508
Phone: (337) 988-3233

CHILDREN'S STRABISMUS QUESTIONNAIRE

Please fill out this questionnaire carefully. Please return it to our office prior to your appointment.

Patient's Name: ______________________________

GENERAL INFORMATION

Were you referred to our office? Yes ☐ No ☐ If not, how did you hear about us?
If yes whom may we thank for this referral? ____________ Phone: ____________
Address: ______________________________
Child's Full Name: ______________________________
Birth Date: ____________________ Age: ______years ______months
Name and address of school: ______________________________

____
Grade: _____ Teacher: ____________ School Nurse: ____________ Principal: ____________
Is your child especially afraid of doctors?______________________________

Please list the names and birth dates of your family:
Father/Caretaker ____________________Birth Date ____________
Mother/Caretaker ____________________Birth Date ____________
Sibling ____________________Birth Date ____________
Sibling ____________________Birth Date ____________
Sibling ____________________Birth Date ____________
Sibling ____________________Birth Date ____________

RESPONSIBLE PERSON INFORMATION

Home Address: ____________ City:____________ Zip: ____________
Home Phone: ____________ Cell Phone: ____________
Father / Caretaker's Occupation: ____________ Business Phone: ____________
Business Address: ____________ City: ____________ Zip: ____________
Mother / Caretaker's Occupation: ____________ Business Phone: ____________
Business Address: ____________ City: ____________ Zip: ____________

MEDICAL HISTORY

Pediatrician's Name: ____________ Date of Last Evaluation: ____________
For what reason? ______________________________
Results and recommendations: ______________________________

____
Child's current state of health: ______________________________
Medications currently using, including vitamins and supplements: ____________

____

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

	Patient	Family	Who		Patient	Family	Who
High blood pressure	☐	☐	______	Glaucoma	☐	☐	______
Diabetes	☐	☐	______	Cataracts	☐	☐	______
Thyroid Condition	☐	☐	______	Blindness	☐	☐	______
Multiple Sclerosis	☐	☐	______	Amblyopia (lazy eye)	☐	☐	______
Brain Tumor	☐	☐	______	Chromosomal Imbalance	☐	☐	______

Any history in your family of an eye turn resulting from a disease or other condition? Yes ☐ No ☐
Other health problems? Yes ☐ No ☐
If yes, please explain: ______________________________
Was there any related trauma, disease, or condition that preceded or accompanied the onset of the eye turn?
Yes ☐ No ☐
If yes, please explain: ______________________________
Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes ☐ No ☐
If yes, please list: ______________________________
List illnesses, bad falls, high fevers, etc.:

Age	Severe	Mild	Complications

Has a neurological evaluation been performed? Yes ☐ No ☐
By whom? ______________________ Results and recommendations: ______________________

Has a psychological evaluation been performed? Yes ☐ No ☐
By whom? ______________________ Results and recommendations: ______________________

Has an occupational therapy evaluation been performed? Yes ☐ No ☐
By whom? ______________________ Results and recommendations: ______________________

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes ☐ No ☐
Did the mother experience any problems during pregnancy? Yes ☐ No ☐
Normal birth? Yes ☐ No ☐
Were forceps used? Yes ☐ No ☐
Any complications before, during or immediately following delivery? Yes ☐ No ☐
Did your child crawl (stomach on floor)? Yes ☐ No ☐ At what age? ______________
Did your child creep (stomach off floor)? Yes ☐ No ☐ At what age? ______________
At what age did your child sit up (without support)? ______________
At what age did your child walk (without support)? ______________
First words: ______________________ At what age? ______________
At what age did your child speak in a simple sentence (string two words together)? ______________
Was your child alert as an infant? Yes ☐ No ☐
Were there ever any concerns regarding growth or development? Yes ☐ No ☐
If so, explain: ______________________________
Child's dominant hand (circle): right or left? Has guidance been given in use of hand? Yes ☐ No ☐

NUTRITIONAL INFORMATION

Current Diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Does your child: Like sweets ☐ or crave sweets ☐

If yes, what types? ______________________________

Are there any food allergies/sensitivities? Yes ☐ No ☐

If so, explain: ______________________________

Is your child active? Yes ☐ No ☐ moderately ☐ extremely ☐

VISUAL HISTORY

At what age did you first notice or suspect that was an eye turning? ______________

Did the eye begin turning - suddenly ☐ or gradually ☐?

Does the eye turn - in ☐ out ☐ up ☐ or down ☐? (check all that apply)

Is the eye turn getting worse or better, or is there no change? ______________

Is it always the same eye that turns? Yes ☐ No ☐

If yes, which eye? Right ☐ Left ☐

Is the eye turn always present? Yes ☐ No ☐

If not, under what conditions is it present? (i.e. when tired, when ill, etc.) ______________

Do you notice if the eye turns more when your child is looking:

up close? .... Yes ☐ No ☐

in the distance? .... Yes ☐ No ☐

to his/her left? .... Yes ☐ No ☐

to his/her 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 report any of the following:

	Yes	No	If yes, when?
Headaches	☐	☐	______
Blurred vision	☐	☐	______
Double vision	☐	☐	______
Eyes “hurt” or “tired”	☐	☐	______
Motion sickness / car sickness	☐	☐	______
Redness of the eyes	☐	☐	______

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

____

Do you feel your child’s vision hinders his/her daily activities in any way? Yes ☐ No ☐

If yes, how? ______________________________

Have you or anyone else ever noticed the following:

	Yes	No	If yes, when
Eyes frequently reddened	☐	☐	______
Frequent eye rubbing	☐	☐	______
Frequent sties	☐	☐	______
Frowning	☐	☐	______
Bothered by light	☐	☐	______
Closes or covers an eye	☐	☐	______
Difficulty seeing distant objects	☐	☐	______
Head close to paper when writing	☐	☐	______
Avoids/dislikes reading or other near tasks	☐	☐	______
Tilts head when reading or writing	☐	☐	______
Moves head when reading	☐	☐	______
Confuses letters and words	☐	☐	______
Reverses letters or words	☐	☐	______

Confuses right or left	☐	☐	____________
Skips, omits words	☐	☐	____________
Loses place when reading	☐	☐	____________
Uses finger as marker	☐	☐	____________
Poor reading comprehension	☐	☐	____________
Comprehension decreases over time	☐	☐	____________
Writes or prints poorly	☐	☐	____________
Difficulty copying form the chalkboard	☐	☐	____________
Tires easily	☐	☐	____________
Difficulty with short term memory	☐	☐	____________
Difficulty with long term memory	☐	☐	____________
Short attention span/loses interest	☐	☐	____________
Poor / awkward large motor coordination	☐	☐	____________
Poor / awkward fine motor coordination	☐	☐	____________
Dislikes/avoids sports	☐	☐	____________
Difficulty hitting / catching a ball	☐	☐	____________

PREVIOUS TREATMENTS

Has your child had a previous visual evaluation? Yes ☐ No ☐

Doctor's Name: ____________ Date of Last Visit: ____________

Results and recommendations: ____________

Were glasses, contact lenses, or other optical devices ever prescribed? Yes ☐ No ☐

If yes, Bifocal: ☐ Single-vision: ☐ Contact lenses: ☐ Other: ☐ Explain: ____________

Are they used? Yes ☐ No ☐

If yes, when are they worn? ____________

If no, why not? ____________

Does the eye turn less when the prescription is worn? Yes ☐ No ☐ Unsure ☐

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: ____________

____

____

Have you ever been told that your child has amblyopia ("lazy eye")? Yes ☐ No ☐

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: ____________

____

Were you satisfied with the results of surgery? Yes ☐ No ☐

Please explain: ____________

Was the surgeon satisfied with the results of surgery? Yes ☐ No ☐

Please explain: ____________

Are you here for a second opinion regarding surgery or further treatment? Yes ☐ No ☐

Has there been any vision therapy? Yes ☐ No ☐

If yes, Doctor's name: ____________

If yes, please describe the type of vision therapy, including its duration, the age at which it started, and an estimate of the results: ____________

____

FAMILY AND HOME

Please indicate which adult(s) he/she lives with? Mother ☐ Father ☐ Stepmother ☐

Stepfather ☐ Foster Parents ☐ Adoptive Parents ☐ Grandmother ☐ Grandfather ☐

Aunt ☐ Uncle ☐ Other Caretaker (please specify): ____________

Does your child spend time with any other person, not in the home? Yes ☐ No ☐

Please explain: ____

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? .... Yes ☐ No ☐

If yes, at what age: ______________________________

Does your child seem to have adjusted? .... Yes ☐ No ☐

Was counseling / therapy undertaken? .... Yes ☐ No ☐

If yes, is it on-going? .... Yes ☐ No ☐

Is family life stable at this time? .... Yes ☐ No ☐

If no, please explain: ____

Please give a brief description of your child as a person:

Is there any other information that would be important / useful in our treatment of your child?

RELEASE OF INFORMATION AND INSURANCE FILING

It is often beneficial to us to discuss examination results and to exchange information with your child's school, pediatrician, and/or other professionals involved in his/her care. Please sign below to authorize this exchange of information.
I agree to permit information from, or copies of, my child's examination records to be forwarded to other health care providers or insurance carriers upon their written request or upon the recommendation of the ADVANCED EYE CENTER when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I authorize Dr. Jong and the ADVANCED EYE CENTER to exchange information with my child's school and other professionals involved in my child's care by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

______________________________________ ________
Parent's or Guardian's Signature Date

I hereby give my permission to the ADVANCED EYE CENTER to treat: ______________________________.
(Child's Name)

______________________________________ ________
Parent's or Guardian's Signature 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 perform a more comprehensive evaluation of your child and to better meet your child's specific visual needs

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us.

You may leave a message with our answering service 24 hours a day / 7 days a week. We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your examination so that we will have the maximum opportunity to evaluate your child's visual status.

Please do not bring any other children with you because your undivided attention is necessary during the evaluation.

THANK YOU.

Sincerely,

Susan Jong, O.D
Clinical Director

Functional Vision Symptom Checklist

Patient Name: ____

Any of the following symptoms may indicate a functional vision problem. Please read and mark the symptoms that occur. This is a critical step in helping us understand the type and amount of functional vision problem that may exist. Check all that apply:

- ☐ Skip lines and / or words when reading or copying
- ☐ Lose place when reading or copying
- ☐ Substitute words when reading or copying
- ☐ Reread words or lines
- ☐ Reverse letters, numbers or words
- ☐ Confuse right and left directions
- ☐ Confuse similar words and letters
- ☐ Poor reading comprehension
- ☐ Difficulty remembering what you have read
- ☐ Comprehension decreasing the longer you read
- ☐ Hold head very close (within 7-8 inches) to reading and/or writing material
- ☐ Squint, close or cover one eye when reading
- ☐ Tilt head in an unusual posture when reading or writing
- ☐ Use a finger or marker to keep place when reading or writing
- ☐ Read very slowly
- ☐ Experience headaches after intense visual activities (reading or computer work)
- ☐ Eyes hurt or feel tired after close work
- ☐ Feel unusually tired after completing a visual task
- ☐ Vision blurs at a distance when looking up from near work
- ☐ Poor spelling skills
- ☐ Crooked or poorly spaced writing
- ☐ Misalign letters and numbers
- ☐ Make errors when copying
- ☐ Tend to lose awareness of surroundings when concentrating
- ☐ Dislike tasks requiring sustained concentration
- ☐ Mind wanders when reading
- ☐ Feel sleepy when reading
- ☐ Become restless when working at a desk
- ☐ Difficulty when tracking moving objects such as balls, etc.
- ☐ Must “feel” things to see them
- ☐ Unusual clumsiness or poor coordination
- ☐ Difficulty with activities requiring eye-hand coordination (sports such as baseball, etc.)
- ☐ Difficulty with activities requiring eye-body coordination (such as dancing, etc.)
- ☐ Carsickness or motion sickness

- ☐ Unusual blinking
- ☐ Unusual eye rubbing
- ☐ Experience symptoms of possible eye strain including:
  - ☐ Dry eyes
  - ☐ Watery eyes
  - ☐ Eyes are red
  - ☐ Eyes are frequently sore
  - ☐ Eyelid twitches
  - ☐ Sensitivity to light
- ☐ Difficulty using binoculars
- ☐ Difficulty judging distances
- ☐ Discomfort in crowded areas with excessive movement
- ☐ Eye turns in
- ☐ Eye turns out
- ☐ One eye sees more clearly than the other with best glasses prescription – Right eye or Left eye
- ☐ Double vision when reading
- ☐ Words or sentences are blurry or wiggly when reading
- ☐ Words or sentences come in and out of focus when reading
- ☐ Words “pop out” at you when reading
- ☐ Words “scrunch together”
- ☐ Words “pull apart” when reading
- ☐ Words move from side to side or up and down when reading
- ☐ Words move, jump, swim or appear to float on the page when reading