FAMILY VISION CARE OPTOMETRY

Supplemental Form - ADULT STRABISMUS (Lazy Eye) QUESTIONNAIRE

This form is to be filled out in addition to the general adult questionnaire which can be found on the forms page if you have been diagnosed with or may have strabismus. Please fill out this questionnaire *carefully* and as thoroughly as possible. There are a total of 4 pages – please be sure you have completed all four pages. You may either print a hard copy and bring it on the day of your appointment or fax it to us at 661-775-9627 prior to your appointment date. THANK YOU.

Date: _____

Patient's Name: _____ Male ☐ Female ☐

MEDICAL HISTORY

Any history in your family of an eye turn resulting from a disease or other condition? Yes ☐ No ☐

If yes, please explain: _____

Was there any related trauma, disease, or condition that preceded or accompanied the onset of your eye turn? Yes ☐ No ☐

If yes, please explain: _____

Are you prone to infections? Yes ☐ No ☐

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

If yes, please list: _____

Has a neurological evaluation been performed? Yes ☐ No ☐

By whom? _____ Results: _____

_____

Has a psychological evaluation been performed? Yes ☐ No ☐

By whom? _____ Results: _____

_____

Has an occupational therapy evaluation been performed? Yes ☐ No ☐

By whom? _____ Results: _____

_____

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NUTRITIONAL INFORMATION

Current Diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Do you: like ☐ or crave ☐ sweets?

Are there any indications that you have been exposed to any toxic substances or fumes?

Yes ☐ No ☐ If so, explain: _____

VISUAL HISTORY

At what age was it first noticed or suspected that there was an eye turn? _____

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 no, under what conditions is it present? _____

_____

Does the eye always turn the same amount? Yes ☐ No ☐

If no, explain: _____

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 ☐

PREVIOUS TREATMENTS

Does the eye turn less when glasses, contacts, or a prescribed optical device 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 done, including the age it started, the eye patched, the duration of treatment, and an estimate of the results:

_____

_____

Has there been any visual therapy? Yes ☐ No ☐

If yes, Doctor's name: _____

Please describe the type of visual therapy, including duration, the age at which it started and an estimate of results: _____

_____

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

Is there any other information that you feel would be helpful / important in our evaluation and/or treatment? Yes ☐ No ☐

If yes, explain: _____

_____

_____

_____

LIFESTYLE CHECKLIST

Please assign a value between 0 and 4 for each symptom.

0 = never or non-existent / 1 = seldom / 2 = occasionally / 3 = frequently / 4 = always

1. Blurred vision	
2. Double vision	
3. Eyes hurt	
4. Eyes tired	
5. Headaches associated with near work	
6. Words run together when reading	
7. Burning, stinging, watery eyes	
8. Falling asleep when reading	
9. Frequent eye rubbing	

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10. Eye frequently reddened	
11. Skipping or repeating lines when reading	
12. Words move around on page when reading	
13. Dizziness or nausea associated with near work	
14. Head tilt or closing one eye when reading	
15. Difficulty copying from the chalkboard	
16. Avoidance of reading and near work	
17. Omitting small words when reading	
18. Writing uphill or downhill	
19. Misaligning digits in columns of numbers	
20. Reading comprehension declining over time	
21. Inconsistent/poor sports performance	
22. Holding reading material too close	
23. Short attention span	
24. Difficulty completing assignments in reasonable time	
25. Saying “I can’t” before trying	
26. Avoiding sports and games	
27. Difficulty with hand tools (i.e. scissors, screwdrivers, calculator, keys)	
28. Reverses letters or words	
29. Tendency to knock things over on desk or table	
30. Motion sickness / car sickness	
31. Difficulty with time management	
32. Difficulty with money concepts and/or making change	
33. Misplaces or loses papers/objects, forgetful, poor memory	
34. Car sickness/ Motion sickness	
35. Reads slowly	
36. Uses finger as a marker to read	
37. Bothered by light	
38. Frequent blinking	
39. Confuses right and left	
40. Glum, sulky, moody, bad temper	

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