FAMILY VISION CARE OPTOMETRY

Supplemental Form - CHILDREN'S STRABISMUS QUESTIONNAIRE

This form is to be filled out in addition to the general child questionnaire which can be found on the forms page if your child has been diagnosed with or may have strabismus. Please fill out this questionnaire *carefully* and as thoroughly as possible. There are a total of 2 pages – please be sure you have completed all two 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 ☐

At what age was it first noticed or suspected 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 ☐

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

If yes, how: _____

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

_____

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PREVIOUS TREATMENTS

Does the eye turn less when glasses, contacts, or any other 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 surgical treatment? Yes ☐ No ☐

If yes, please describe the surgery, including the age surgery was performed, the number of operations, the eye(s) operated on, and an estimate of the cosmetic and subjective results:

_____

_____

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

_____

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

_____

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

Has there been any visual therapy? Yes ☐ No ☐ .

If yes, Doctor's name: _____

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

_____

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

_____

_____

You must print this document to save your filed form. Please click here to print