CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
Developmental Optometrist

Dr. Amber Cumings, FAAO
Developmental/Pediatric/
Neuro-Optometrist

Dr. Delia Malone
Developmental/Neuro-Optometrist

CHILDREN'S STRABISMUS QUESTIONNAIRE

Child's Name: _____ Male _____ Female _____
Birth Date: _____ Age: _____years _____months
Reason for Visit: _____

Were you referred to our office? Yes ☐ No ☐
If yes, whom may we thank for this referral? _____ Phone: _____
Address: _____ Email Address: _____
If not referred, how did you learn about our office? _____

RESPONSIBLE PERSON INFORMATION:

Father/Caretaker: _____ Cell Phone:_____ Occupation: _____
Mother/ Caretaker: _____ Cell Phone:_____ Occupation: _____

Name and address of school: _____
Grade: _____ Teacher: _____School Nurse: _____ Principal: _____
_____

PATIENT'S MEDICAL HISTORY:

Pediatrician's Name:_____Date of last Evaluation: _____
Medications currently used, including vitamins and supplements:

1. _____ Condition: _____
2. _____ Condition: _____
3. _____ Condition: _____
4. _____ Condition: _____

Allergies to foods or medications. If yes, please list:_____
List illnesses, bad falls, high fevers, etc.:

	Illness	Age	Severity (Mild-Severe)	Complications
1.				
2.				
3.				

Is your child generally healthy? Yes ☐ No ☐
If no, explain: _____
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 ☐
If yes, by whom? _____
Results and recommendations: _____

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Has a psychological evaluation been performed? Yes ☐ No ☐
If yes, by whom? _____
Results and recommendations: _____
Has an occupational therapy evaluation been performed? Yes ☐ No ☐
If yes, by whom? _____
Results and recommendations: _____
Has a speech therapy evaluation been performed? Yes ☐ No ☐
If yes, by whom? _____
Results and recommendations: _____
Has your child been evaluated by any other medical specialist? Yes ☐ No ☐
If yes, by whom? _____
Results and recommendations: _____

HEALTH HISTORY: Check any conditions that apply to your child or that run in your family.

Diabetes	☐ Child	☐ Family	Epilepsy/Seizures	☐ Child	☐ Family
High blood pressure	☐ Child	☐ Family	Color "blind"	☐ Child	☐ Family
High Cholesterol	☐ Child	☐ Family	Nearsighted	☐ Child	☐ Family
Thyroid	☐ Child	☐ Family	Farsighted	☐ Child	☐ Family
Heart problem	☐ Child	☐ Family	Refractive Eye Surgery (Lasik, PRK)		☐ Family
Cancer	☐ Child	☐ Family	Glaucoma	☐ Child	☐ Family
Respiratory Disease	☐ Child	☐ Family	Cataracts		☐ Family
Ear/Nose/Throat Problems	☐ Child	☐ Family	Macular degeneration		☐ Family
Muscle/Bone/Joint Problems	☐ Child	☐ Family	Retinal Detachment	☐ Child	☐ Family
GI Problems	☐ Child	☐ Family	Blindness	☐ Child	☐ Family
Skin Problems	☐ Child	☐ Family	Lazy Eye	☐ Child	☐ Family
Psychiatric Problems	☐ Child	☐ Family	Crossed Eyes	☐ Child	☐ Family
Allergies/Immunologic Problems	☐ Child	☐ Family	ADD/ADHD	☐ Child	☐ Family
Migraines/headaches	☐ Child	☐ Family	Learning Disability	☐ Child	☐ Family
Head Trauma/Concussion	☐ Child	☐ Family	Dyslexia	☐ Child	☐ Family

Other medical conditions:_____

_____

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: _____

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DEVELOPMENTAL HISTORY:

Was the pregnancy full term? Yes ☐ No ☐
Did the mother experience any health problems during the pregnancy? Yes ☐ No ☐
If yes, explain: _____
Were there any complications before, during or immediately following delivery? Yes ☐ No ☐
If yes, explain: _____
Was there ever any reason for concern over your child's general growth or development?
If yes, explain: _____

DEVELOPMENTAL MILESTONES: Please list the age your child was able to complete the following tasks:

Age:	Task
_____	Crawl on stomach on the floor
_____	Crawl on all fours
_____	Walk
_____	First words

Was speech clear to others? Yes ☐ No ☐ Is speech clear now? Yes ☐ No ☐

OCULAR HISTORY

At what age did you first notice or suspect 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 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	☐	☐	_____

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING IN YOUR CHILD:

	Yes	No	If yes, when?
Eyes frequently reddened	☐	☐	_____
Frequent eye rubbing	☐	☐	_____
Frequent sties	☐	☐	_____

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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: _____
Wears 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 ☐
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:

_____
_____

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:

_____
_____

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Are you here for a second opinion regarding surgery or further treatment? Yes ☐ No ☐
Has there been any visual therapy? Yes ☐ No ☐
If yes, Drs. name: _____
If yes, please describe the type of visual therapy, including its duration, the age at which it started, and an estimate of the results: _____
_____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON: _____
_____
_____
_____
_____
_____

IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL/IMPORTANT IN OUR TREATMENT OF YOUR CHILD?
_____
_____
_____
_____
_____

RETINAL IMAGING

We are pleased to provide our patients with an advanced digital retinal exam. It is great for documenting a baseline image for our charts, screen for eye diseases, and improve our ability to view your internal retinal health. A dilated exam may still be recommended by the doctor if a more peripheral view of the retina is indicated. Since insurance only covers retinal photos after eye disease is discovered, the Retinal Imaging Exam is an out-of-pocket expense. **The fee is $45.00.**

☐ I want my child to have the retinal health evaluated with Retinal Imaging.

☐ I do not wish to have Retinal Imaging Exam for my child. I understand that a thorough eye exam with dilation will be performed.

Signature _____ Date _____

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