CLARENDON VISION DEVELOPMENT CENTER

**Dr. Monika Spokas**
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**Dr. Dana Shannon, FAAO**
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# 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 | ☐ | ☐ | _____ |

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| | Yes | No | If yes, when? |
|---|---|---|---|
| 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: _____
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 ☐

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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:

_____

_____

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?

_____

_____

_____

_____

## WELLNESS ASSESSMENT

Introducing Our Enhanced Eye Wellness Exam! Experience the next level of eye care with our Eye Wellness Exam, now including a fundus photo. This advanced digital retinal exam offers several benefits for your eye health. Firstly, it allows us to assess the health of your macula, which is vital for clear central vision. Additionally, it helps us screen for common eye diseases such as macular degeneration and glaucoma. The exam establishes a baseline for your eye health history, aiding in the early detection of any vital changes. It's important to note that insurance typically covers retinal photos only when an eye disease is already detected. In certain instances, the doctor might suggest a dilated exam to obtain a more thorough view of your retina, but only if deemed necessary based on the findings of this examination. Your eye health is our priority, and we're committed to providing you with the best care possible. The Retinal Imaging Exam comes at an out-of-pocket cost of **$55.00.**

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

☐ I do not wish to have the Retinal Imaging Exam. I understand that I will still have a thorough eye exam with possible dilation.

Signature _____ Date _____