CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
Developmental Optometrist

Dr. Amber Cumings, FAAO
Developmental/Pediatric/
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? _____
Please list the names and birth dates of your family:

NAME

Father/Caretaker: _____ Birth Date: _____
Mother/Caretaker: _____ Birth Date: _____
Sibling: _____ Birth Date: _____
Sibling: _____ Birth Date: _____
Sibling: _____ Birth Date: _____
Sibling: _____ Birth Date: _____

Name and address of school: _____
Grade: _____ Teacher: _____ School Nurse: _____
Social Worker: _____ Principal: _____

RESPONSIBLE PERSON INFORMATION:

Home Address: _____ City: _____ Zip: _____
Home Phone: _____ Mother/Father Cell Phone: _____
Father/Caretaker's Occupation: _____ Place of Employment: _____
Business Phone: _____ Email Address: _____
Mother/Caretaker's Occupation: _____ Place of Employment: _____
Business Phone: _____ Email Address: _____

PATIENT'S MEDICAL HISTORY:

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

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

Allergies to foods or medications. If yes, please list: _____

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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: _____

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: _____

PATIENT'S MEDICAL HISTORY: Please mark an "X" on conditions that apply.

_____ Strabismus (Crossed Eyes)
_____ Amblyopia (Poor Vision)
_____ Learning Disability
_____ Dyslexia
_____ ADD/ADHD
_____ Asperger's Syndrome/Autism
_____ Epilepsy/Seizure
_____ Chromosomal Imbalance
_____ Diabetes
_____ Thyroid Condition
_____ Brain Tumor/Brain Injury/Concussion
_____ Other, please list:_____

FAMILY MEDICAL HISTORY: Please mark an "X" on all conditions that apply and list the family member(s) who has the following condition?

_____ High Cholesterol - Family Member(s): _____
_____ Thyroid - Family Member(s): _____
_____ Heart Disease - Family Member(s): _____
_____ Cancer - Family Member(s): _____
_____ Diabetes - Family Member(s): _____

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_____ High Blood Pressure - Family Member(s): _____
_____ Glaucoma - Family Member(s): _____
_____ Cataracts - Family Member(s): _____
_____ Macular Degeneration – Family Member(s): _____
_____ Retinal Detachment - Family Member(s): _____
_____ Strabismus (Crossed Eyes) - Family Member(s):_____
_____ Amblyopia (Poor Vision) - Family Member(s): _____
_____ Near-Sighted - Family Member(s): _____
_____ Far-Sighted - Family Member(s):_____
_____ Other - Family Member(s): _____

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: _____

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 ☐

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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	☐	☐	_____
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 ☐

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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:

_____

_____

Were you 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 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: _____

_____

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): _____
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: _____

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?

_____

_____

_____

_____

_____

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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 $35.00.**

☐ 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 _____

PAYMENT POLICY / HIPAA

Examination and procedure fees are due at the time of service and may be submitted to your major medical insurance carrier. Any applicable co-payments are due at the time of service. If you have insurance coverage for these services or materials, we will submit claims for you. However, we are not liable for collecting your claim. After 30 days, we will expect payment in full if your insurance company has not paid. Any balance 90 days after the date of service will incur a monthly billing service charge of $2.00 or 1.3% (15.6% APR) whichever is greater until the balance is paid in full. Returned NSF checks will be charged a service fee of $35.00.

I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT DIRECTLY TO CLARENDON VISION DEVELOPMENT CENTER FOR ANY AND ALL SERVICES RENDERED TO ME BY CLARENDON VISION DEVELOPMENT CENTER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

- I HAVE READ AND AGREE TO THE PAYMENT POLICY STATED ABOVE.

THE OFFICE'S COMPLETE HIPAA POLICY STATEMENT IS AVAILABLE FOR REVIEW UPON REQUEST.

- I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW THE OFFICE'S HIPAA POLICY STATEMENT.

Signature of Responsible Party _____ Date _____

APPOINTMENT CANCELLATION / NO SHOW POLICY

Thank you for trusting your medical care to Clarendon Vision Development Center. When you schedule an appointment with Clarendon Vision Development Center, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

- Please provide our office a 24-hour notice if you need to reschedule or cancel your appointment.
- A "No-Show", "No-Call" or missed appointment, without proper 24-hour notification, will be charged a $150 fee. In the event of an emergency where prior notice could not be given, consideration will be given, and a one-time exception may be granted.
- If you are more than 10 minutes late for your appointment, the appointment may be cancelled and rescheduled.
- If a reminder call or message from our office is not received by the patient, the cancellation policy still remains in effect.

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- The cancellation/no show fees are the sole responsibility of the patient and must be paid in prior to the patient's next appointment.
- This fee is not billable to your insurance.

If you have any questions regarding this policy, please let our staff know and we will be glad to answer them.

I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.

Signature of Responsible Party _____ Date _____

Thank you for carefully completing this questionnaire. The information you supplied will allow us to provide a more comprehensive evaluation and better meet your child's specific visual needs.

If you have any questions, please contact our office at (630) 323-7300 prior to your appointment.

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