

ADULT STRABISMUS QUESTIONNAIRE

Please fill out this questionnaire carefully. Please return it to our office prior to your appointment in the envelope provided. Thank you.

Appointment: Day _____ Date _____ Time _____
 Patient's Name: _____

GENERAL INFORMATION

Full Name: _____ Male Female
 Birth Date: _____ Age: _____
 Home Address: _____
 Home Phone: _____ Work Phone: _____
 Marital status: Single Married Divorced Widowed
 Were you referred to our office? Yes No
 If yes, whom may we thank for this referral? _____ Phone: _____
 Address _____
 Do you have Major Medical Insurance? Yes No
 If yes, who is the carrier? _____ Policy #: _____
 Does the insurance cover eye examinations or glasses? Yes No
 Name of Insured: _____
 Social Security Number: _____ Driver's License No.: _____
 What is your occupation? _____ Employer: _____
 Business Address: _____
 Spouse's Name: _____ Occupation: _____
 Spouse's Employer: _____ Phone #: _____
 Business Address: _____

MEDICAL HISTORY

Is there any history of the following? (please check if there is a history)

	<u>Patient</u>	<u>Family</u>	<u>Who</u>		<u>Patient</u>	<u>Family</u>	<u>Who</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Turn	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>	_____
Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Infections	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>	_____

Physician's Name: _____ Date of Last Evaluation: _____
 For what problem / condition? _____
 Results and recommendations: _____
 Medications currently using including vitamins and supplements: _____
 For what condition(s)? _____

Are you allergic to any foods or medications? Yes No

If yes, please list: _____

Current state of health (explain): _____

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 the 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: _____

List illnesses, bad falls, high fevers, ear infections, etc.:

<u>Age</u>	<u>Severe</u>	<u>Mild</u>	<u>Complications</u>
_____	_____	_____	_____
_____	_____	_____	_____

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: _____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes No

Did the mother experience any problems during the pregnancy? Yes No

If yes, explain: _____

Normal birth? Yes No

If No, explain: _____

Were forceps used? Yes No

Any complications before, during or immediately following delivery? Yes No

If yes, explain: _____

Were there ever any concerns regarding growth or development? Yes No

If yes, explain: _____

NUTRITIONAL INFORMATION

Current Diet: Excellent Good Fair Poor

Do you: like (or) crave sweets? Yes No

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

Yes No If yes, explain: _____

VISUAL HISTORY

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 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

Do you experience any of the following:

	Yes	No	If yes, when?
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes tired	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes hurt	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motion sickness / car sickness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent sties	<input type="checkbox"/>	<input type="checkbox"/>	_____
Red or bloodshot eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bothered by light	<input type="checkbox"/>	<input type="checkbox"/>	_____
Closing or covering an eye to see better	<input type="checkbox"/>	<input type="checkbox"/>	_____
Need to hold paper close when reading or writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head tilt	<input type="checkbox"/>	<input type="checkbox"/>	_____
Confusion of letters or words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skipping or omitting words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of place when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Need to use finger to keep place	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor reading comprehension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Comprehension decreases over time	<input type="checkbox"/>	<input type="checkbox"/>	_____
Write or print poorly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fatigue easily	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with short term memory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with long term memory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Short attention span / loss of interest	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty attending to details	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor / awkward general motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor fine motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty judging distances	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty driving	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dislike / avoid sports	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty hitting or judging moving targets during sports	<input type="checkbox"/>	<input type="checkbox"/>	_____

List any other complaints you have concerning vision: _____

Do you feel your vision handers your daily activities in any way? Yes No

If yes, explain: _____

Do you feel your vision limits your potential in any way? Yes No If yes, explain: _____

PREVIOUS TREATMENTS

Have you had a previous visual evaluation? Yes No

If yes, Doctor's Name: _____ Date of last evaluation: _____

Results and recommendations: _____

Were glasses, contact lenses, or other optical devices recommended or prescribed? Yes ___ No ___

If yes, bifocal? single vision? contact lenses? Other? Explain: _____

Are they worn? Yes No

If yes, when? _____

If no, why not? _____

Does the eye turn less when the prescription is worn? Yes No Unsure

Have you been told that you have amblyopia (lazy eye)? Yes No

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(s) operated on, and an estimate of the cosmetic and subjective results: _____

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

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

Have surgical results been maintained? Yes No Explain: _____

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

EMPLOYMENT OR SCHOOL

Current position: _____ Major course of study: _____

How many hours daily do you spend at a desk? _____

How many hours daily do you spend reading or studying? _____

How many hours daily do you spend working at near distances? _____

Are you achieving to your potential in work or school? Yes No

Do you feel you are getting adequate return for the amount of effort you put into a task? Yes No

Does your work or course of study demand comprehension from the written word? Yes No

Describe briefly your daily activities at work or in school: _____

HOBBIES/LEISURE TIME

Describe the types of activities that comprise the majority of your spare time: _____

Do you watch TV? Yes No

If yes, how many hours per day? _____ How many days per week? _____

Are you seriously involved with athletics? Yes No

Do you feel you are achieving up to your potential in athletics? Yes No

Of all the sports you have played:

List the ones in which you excel: _____

List the ones in which you do poorly / avoid: _____

Do you feel your vision limits or prevents you from participating in any activities? Yes No

If so, explain what and how: _____

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

If yes, explain: _____

RELEASE OF INFORMATION AND INSURANCE FILING

It is often beneficial to discuss examination results and to exchange information with other co-managing professionals. Please sign below to authorize the release of information.

I agree to permit information from, or copies of, my examination records to be exchanged with other health care providers or provided to insurance carriers upon their written request or upon the recommendation of the VISION DEVELOPMENT CENTER, P.C., when it is necessary for treatment or for the processing of insurance claims. This authorization shall be valid for the duration of treatment.

Signature or Authorized Representative

Date

WAIVER OF DILATED FUNDUS EXAM

Services offered at the VISION DEVELOPMENT CENTER, P.C. do not include dilation and evaluation of ocular health. Dilation involves instilling drops in your eyes to enlarge the pupils. This allows your primary care optometrist to see better into the back of the eyes and evaluate the health of the eyes.

I understand that it is the recommendation of Vision Development Center, P.C. that a dilated fundus exam be performed prior to receiving the services offered therein. I also understand that refusing to have my eyes dilated may result in various ocular diseases to go undetected which may adversely affect my eyes and/or vision.

Signature or Authorized Representative

Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us. We request a minimum of 24 hours notice if you are unable to keep this appointment.

Thank you!



Joan Bauernfiend, O.D.
Vision Development Center, P.C.