J. Robert Walesby, O.D.,F.C.O.V.D.
Shereé Wright, O.D.

WALESBY VISION CENTER
"Where Vision Is More Than Just 20/20"

Nicholas Thomas, O.D., F.C.O.V.D.
Clinical Director of Vision Therapy

ADULT STRABISMUS QUESTIONNAIRE

Please fill out this questionnaire carefully & completely & submit it to our office ***FOUR BUSINESS DAYS PRIOR*** *to your Screening or Work-Up appointment. Thank you.*

Appointment: Day: _____ Date: _____ Time: _____

Patient's Name: _____

How did you hear about us?

- ☐ Referred by _____ Reason: _____
- ☐ Internet (specify) _____ ☐ Insurance (Carrier) _____
- ☐ Yellow Pages/ White Pages ☐ Television
- ☐ Drive by ☐ Other (specify) _____

GENERAL INFORMATION

Full Name: _____ Male ☐ Female ☐
Birth Date: _____ Age: _____ Social Security Number: _____
Home Address: _____ City: _____ Zip: _____
Home Phone: ( ) _____ Cell Phone: ( ) _____ Fax #: ( ) _____
Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐
What is your occupation? _____ Employer: _____
Spouse's Name: _____ Occupation: _____
Spouse's Employer: _____ Phone #: ( ) _____

FAMILY MEMBERS

NAME

Spouse: _____ Birth Date: _____
Dependent: _____ Birth Date: _____
Dependent: _____ Birth Date: _____
Dependent: _____ Birth Date: _____

MEDICAL HISTORY

Physician: _____ Date of Last Evaluation _____
Reason for Visit: _____
Results and recommendations: _____
Current medications, including vitamins and supplements: _____
_____
For what condition(s): _____
_____
Are you allergic to any foods or medications? Yes ☐ No ☐ If yes, please list: _____
_____
Current diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Current state of health (explain): _____

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

	Patient	Family (who)		Patient	Family (who)
High blood pressure	☐	☐	Glaucoma	☐	☐
Diabetes	☐	☐	Cataracts	☐	☐
Thyroid Condition	☐	☐	Epilepsy or Seizures	☐	☐
Multiple Sclerosis	☐	☐	Amblyopia (lazy eye)	☐	☐
Brain Tumor	☐	☐	Chromosomal Imbalance	☐	☐

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 ☐
List illnesses, injuries, head trauma, high fevers, etc.:

Age	Severe/Mild	Complications

Are there any chronic problems (ear infections, asthma, hay fever, allergies, etc.)? Yes ☐ No ☐
If yes, please list: _____
Has a neurological evaluation been performed? Yes ☐ No ☐ **If yes, Please Provide a Copy**
By whom? _____ Results and recommendations: _____

Has a psychological evaluation been performed? Yes ☐ No ☐ **If yes, Please Provide a Copy**
By whom? _____ Results and recommendations: _____

Has an occupational therapy evaluation been performed? Yes ☐ No ☐ **If yes, Please Provide a Copy** By whom? Results and recommendations: _____

DEVELOPMENTAL HISTORY
Full-term pregnancy? Yes ☐ No ☐ _____ weeks early
Did the mother experience health problems during the pregnancy? Yes ☐ No ☐
If yes, explain: _____
Method of delivery: Cesarean Section ☐ Vaginal ☐
Complications before, during, or following delivery? Yes ☐ No ☐
If yes, explain: _____
Were forceps used? Yes ☐ No ☐ Was a Vacuum Extraction used? Yes ☐ No ☐
Was there reason for concern over your general growth or development? Yes ☐ No ☐
If yes, explain: _____

NUTRITIONAL INFORMATION
Current Diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Do you: Like sweets ☐ and/or crave sweets ☐
Are there any indications that you have been exposed to any toxic substances or fumes? Yes ☐ No ☐
If so, explain: _____

VISUAL HISTORY

At what age did you first noticed or suspected that your eye was turning? _____

Did the eye begin turning ☐ suddenly ☐ gradually

Does the eye turn in ☐ out ☐ up ☐ or down ☐ (check all that apply)?

Is the eye turn getting worse ☐ 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 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 experience any of the following:

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

	Yes	No	If yes, when?
Difficulty driving	☐	☐	_____
Dislike / avoid sports	☐	☐	_____
Difficulty hitting or judging moving targets during sports	☐	☐	_____

List any other complaints you have concerning vision: _____

_____

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

If yes, explain: _____

_____

PREVIOUS TREATMENTS

Have you had a previous visual evaluation? Yes ☐ No ☐

If so, 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 ☐ (Specify): _____

Are they used? 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? _____
Do you feel you are 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 ☐
If no, please explain:_____
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 FOR US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH YOUR CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I agree to permit information from, or copies of my examination records to be forwarded to other health care providers or insurance carriers upon written request or recommendation of the WALESBY VISION CENTER when deemed necessary for treatment of my visual condition, or processing of insurance claims.

_____ _____

Signature of patient or authorized representative Date

This authorization is valid for the duration of treatment. Thank you for carefully completing this questionnaire. The information provided allows for a more efficient use of time, enabling us to perform a more comprehensive evaluation and better meet his/her specific visual needs.

If you have questions or concerns prior to your appointment, please do not hesitate to contact us.

A minimum cancellation notice of 48 hours is required, as previously agreed, or a $360 service charge will be processed. You may leave a voicemail at our office number at any time.

Please be prompt for the appointment, in order to maximize the time reserved to evaluate his/her visual status.

Your undivided attention is necessary during this evaluation; it is, therefore, advisable not to bring other children.

Your child may benefit from bringing something to occupy his/her time while you are in conference with the doctor.

Sincerely,

J. Robert Walesby, O.D., F.C.O.V.D.
Shereé Wright, O.D.

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Clinical Director of Vision Therapy

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