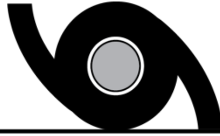
J. Robert Walesby, O.D.,F.C.O.V.D.
Shereé Wright, O.D.



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

CHILDREN'S 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 Date: ____________________ Time: ____________
Patient's Name: ________________________________

REFERRED BY:

Eye Doctor: ____________________ Address: ____________________
OT: ____________________ City, State Zip: ____________________
Psychologist: ____________________ Phone #: (____) ____-________
Other (specify): ________________________________

GENERAL INFORMATION

Child's Full Name: ________________________________ Male ☐ Female ☐
Birth Date: ____________________ Age: ______ years ______ months
Home Address: ____________________ City: ____________ Zip: ______
Primary Phone #: (___)____-______ Alternate Phone #:(___) ____ - _____ Fax (_____)____-_____
Occupation Father/Guardian: ____________________ Work/Cell #: (_____)____-_____
Occupation Mother/Guardian: ____________________ Work/Cell #: (_____)____-_____
Email: Father ____________________ Mother ____________________

FAMILY MEMBERS

NAME

Father/Guardian: ____________________ Birth Date: ____________
Mother/Guardian: ____________________ Birth Date: ____________
Sibling: ____________________ Birth Date: ____________
Sibling: ____________________ Birth Date: ____________
Sibling: ____________________ Birth Date: ____________
Sibling: ____________________ Birth Date: ____________

SCHOOL INFORMATION

Name of school: ____________________ Location: ____________
Grade: ________ Teacher 1: ____________________ Teacher 2: ____________
Guidance Counselor: ____________________ Principal: ____________
Child's dominate hand: right ☐ left ☐ Has guidance been given in use of hand? Yes ☐ No ☐

MEDICAL HISTORY

Pediatrician: ________________________________ Date of Last Evaluation: ________________

Reason for Visit: ____

Results and recommendations: ____

____

Child's current state of health: ____

Current medications, including vitamins and supplements: __________________________

____

For what condition(s): ____

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 ☐ Other health problems? 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: ______________________________

____

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: ___________________________________

____

NUTRITIONAL INFORMATION

Current Diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Does he/she: Like sweets ☐ and/or crave sweets ☐

If yes, what type(s)? ____

Is he/she physically active? Yes ☐ No ☐ Normal ☐ Extreme ☐

Are there periods of very high energy? Yes ☐ No ☐ periods of very low energy? Yes ☐ No ☐

Explain: ____

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: ____________________

Birth weight: ____lbs ____oz Apgar scores @ birth: ________ After 10 minutes: ________

Were forceps used? Yes ☐ No ☐ Was a Vacuum Extraction used? Yes ☐ No ☐

Was there reason for concern over his/her general growth or development? Yes ☐ No ☐

If yes, explain: ____________________

Did he/she creep (stomach on floor)? Yes ☐ No ☐ age: ____________

At what age did he/she sit up (without support)? age: ____________

Did he/she crawl (on all fours and without support)? Yes ☐ No ☐ age:________

If not, describe: ____________________

At what age did he/she walk? ____________

Was he/she active as an infant? Yes ☐ No ☐

Speech: First words: ____________________ age: ________

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

At what age did your child speak in a simple sentence (string two words together)? ________

Was your child alert as an infant? Yes ☐ No ☐

VISUAL HISTORY

At what age did you first noticed or suspected that his/her 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 he/ she looks:

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 he/she 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	☐		________

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

List any other complaints he/she has concerning vision: ______

Do you feel his/her vision hinders his/her daily activities in any way? Yes ☐ No ☐
If yes, explain: ______

PREVIOUS TREATMENTS

Has his/her vision been previously evaluated? Yes ☐ No ☐
If so, Doctor's Name: ______ Date of last evaluation: ______
Reason for examination: ______
Results and recommendations: ______
Were glasses, contact lenses, or other optical devices recommended? Yes ☐ No ☐
If yes, Bifocal: ☐ Single-vision: ☐ Contact lenses: ☐ Other: ☐ Explain: ______
Are they used? Yes ☐ No ☐ If yes, when are they worn? ______
If no, why not? ______
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: ______

Have you ever been told that he/she has amblyopia ("lazy eye")? Yes ☐ No ☐
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: ______________________________
Was the surgeon 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, Doctor's 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: ______________________________

____

TELEVISION VIEWING/LEISURE TIME ACTIVITIES
Does child watch TV? _______ How much? _______ How often? _______ Viewing distance? _______
Does he/she spend time using computer/video games? Yes ☐ No ☐
If yes, how much? __________ Frequently: __________ Viewing distance: __________
What other activities occupy his/her leisure time? ______________________________
Are there any activities he/she would like to participate in, but doesn't? ______________
Please explain: ______________________________

____

SCHOOL
Age at time of entrance to: Pre-school: _______ Kindergarten: _______ First Grade: _______
Does he/she like school? Yes ☐ No ☐
Does he/she like to read? Yes ☐ No ☐
Voluntarily? Yes ☐ No ☐ For pleasure? Yes ☐ No ☐
What: ______________________________
What is his/her attitude toward reading, school, teacher(s), peers? ______________

____
Overall schoolwork is: above average ☐ average ☐ below average ☐
Specifically describe any school difficulties: ______________________________

____
Has he/she changed schools often? Yes ☐ No ☐ If yes, when? ______________
Has a grade been repeated? Yes ☐ No ☐ If yes, which and why? ______________

____
Does he/she seem stressed or pressured when doing schoolwork? Yes ☐ No ☐
Has he/she had tutoring, therapy, and/or remedial assistance? Yes ☐ No ☐
If yes, from whom: ______________ Title: (OT, PT, SLP, etc.) ______________
Currently attending? Yes ☐ No ☐ How long: ______________ How Often: ______________
Address: ______________________________
Results: ______________________________

WHICH SUBJECTS ARE:
Above average: ______________________________
Average: ______________________________
Below average: ______________________________
Does he/she spend excessive time/effort to maintain this level of performance? Yes ☐ No ☐
How much time (average) is spent on homework daily? ______________________________
To what extent do you assist him/her with homework? None ☐ Partial ☐ Full ☐
Do you feel he/she is achieving up to full potential? Yes ☐ No ☐
Does his/her teacher feel that he/she is achieving up to full potential? Yes ☐ No ☐

GENERAL BEHAVIOR

Are there any behavior problems at school? Yes ☐ No ☐

If yes, what? ____________________

Are there any behavior problems at home? Yes ☐ No ☐

If yes, what? ____________________

What causes these problems? ____________________

Child's reaction to fatigue? drowsy ☐ irritable ☐ other ☐ ____________________

Child's reaction to tension/stress? avoidance ☐ irritable ☐ other ☐ ____________________

Does he/she say and/or do things impulsively? Yes ☐ No ☐

Is he/she in constant motion? Yes ☐ No ☐

Can he/she sit still for long periods of time? Yes ☐ No ☐

FAMILY AND HOME

With whom does child reside? Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐

Foster Parents ☐ Adoptive Parents ☐ Grandmother ☐ Grandfather ☐

Aunt ☐ Uncle ☐ Other Caregiver (please specify): ____________________

Does he/she spend time with any other person, not in the home? Yes ☐ No ☐

Please explain: ____________________

Has he/she experienced a family trauma (separation, divorce, chronic illness, parental loss, etc.)?

Yes ☐ No ☐ If yes, at what age: __________

Does he/she seem to have adjusted? Yes ☐ No ☐

Was counseling/therapy utilized? Yes ☐ No ☐

If yes, is it on-going? Yes ☐ No ☐

Is family life stable at this time? Yes ☐ No ☐

If no, please explain: ____________________

How does he/she get along with:

Parents/other caregivers: ____________________

Siblings: ____________________

Classmates: ____________________

Playmates at home: ____________________

Is there a family history of learning or developmental delay? Yes ☐ No ☐

Paternal: ____________________

Maternal: ____________________

Siblings: ____________________

Specify Condition: ____________________

____

____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD. INCLUDE INFORMATION THAT MAY BE HELPFUL IN HIS/HER TREATMENT/ DIAGNOSIS:

____

____

____

____

____

____

____

____

____

RELEASE OF INFORMATION AND INSURANCE FILING

IT IS OFTEN BENEFICIAL FOR US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION REGARDING YOUR CHILDS PEDIATRICIAN, SCHOOL, OR OTHER PROFESSIONALS INVOLVED IN HIS/HER CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I agree to permit copies of my child's 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 his/her visual condition, or processing of insurance claims.

________________________________ ____________
Parent's or Guardian's Signature Date

I do hereby give my permission to the WALESBY VISION CENTER to treat ____________________
(Child's Name)

________________________________ ____________
Parent's or Guardian's Signature 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.

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

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