Lighthouse Optometric Vision Performance Center, 1556 ½ Meridian Ave., San Jose, CA 95125
Phone: 408-445-2105 Website: www.LighthouseVT.com Email: Lighthousevision@att.net

CHILDREN'S STRABISMUS QUESTIONNAIRE

Please fill out this questionnaire carefully.

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

GENERAL INFORMATION

Were you referred to our office ? Yes ☐ No ☐
If yes whom may we thank for this referral? _____ Phone: _____
Address: _____
Child's Full Name: _____
Birth Date: _____ Age: _____years _____months
Name and address of school: _____
Grade: _____ Teacher: _____ School Nurse: _____ Principal: _____
Is your child especially afraid of doctors? _____
Child's dominant hand (circle): right or left? Has guidance been given in use of hand? Yes ☐ No ☐

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	_____

RESPONSIBLE PERSON INFORMATION

Home Address: _____ City: _____ Zip: _____
Home Phone: _____ Business Phone: _____
Father / Caretaker's Occupation: _____ Business Phone: _____
Business Address: _____ City: _____ Zip: _____
Mother / Caretaker's Occupation: _____ Business Phone: _____
Business Address: _____ City: _____ Zip: _____
Do you have Major Medical Insurance? Yes ☐ No ☐
If so, who is the carrier? _____ Policy #: _____
Name of Insured: _____
Social Security Number: _____ Driver's License #: _____

MEDICAL HISTORY

Pediatrician's Name: _____ Date of Last Evaluation: _____
For what reason? _____
Results and recommendations: _____
_____
Child's current state of health: _____
Medications currently using, including vitamins and supplements: _____
_____
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	☐	☐	_____	Blindness	☐	☐	_____
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: _____
Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes ☐ No ☐
If yes, please list: _____
List illnesses, bad falls, high fevers, etc.:

Age	Severe	Mild	Complications

Has a neurological evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations: _____
Has a psychological evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations: _____
Has an occupational therapy evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations: _____

DEVELOPMENTAL HISTORY
Full-term pregnancy? Yes ☐ No ☐
Did the mother experience any problems during pregnancy? Yes ☐ No ☐
Normal birth? Yes ☐ No ☐
Were forceps used? Yes ☐ No ☐
Any complications before, during or immediately following delivery? Yes ☐ No ☐
Did your child crawl (stomach on floor)? Yes ☐ No ☐ At what age? _____
Did your child creep (stomach off floor)? Yes ☐ No ☐ At what age? _____
At what age did your child sit up (without support)? _____
At what age did your child walk (without support)? _____
First words: _____ At what age? _____
At what age did your child speak in a simple sentence (string two words together)? _____
Was your child alert as an infant? Yes ☐ No ☐
Were there ever any concerns regarding growth or development? Yes ☐ No ☐
If so, explain: _____

NUTRITIONAL INFORMATION

Current Diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Does your child: Like sweets ☐ or crave sweets ☐

If yes, what types? _____

Are there any food allergies/sensitivities? Yes ☐ No ☐

If so, explain: _____

Is your child active? Yes ☐ No ☐ moderately ☐ extremely ☐

VISUAL HISTORY

At what age did you first notice or suspect 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 urn 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	☐	☐	

List any other complaints your child makes concerning his/her vision: _____

_____

Do you feel your child’s vision hinders his/her daily activities in any way? Yes ☐ No ☐

If yes, how? _____

Have you or anyone else ever noticed the following:

	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	☐	☐	

	Yes	No	If yes, when
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: _____

Were 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 ☐

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 your child 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, 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): _____
Does your child spend time with any other person, not in the home? Yes ☐ No ☐
Please explain: _____
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: _____
Does your child seem to have adjusted? Yes ☐ No ☐
Was counseling/therapy undertaken? Yes ☐ No ☐
If yes, is it on-going? Yes ☐ No ☐
Is family life stable at this time? Yes ☐ No ☐
If no, please explain: _____
Please give a brief description of your child as a person:

Is there any other information that would be important/useful in our treatment of your child?

IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH YOUR CHILD'S SCHOOL AND/OR OTHER PROFESSIONALS INVOLVED IN HIS/HER CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I agree to permit information from, or copies of, my child's examination records to be forwarded to my child's school, other than health care providers or insurance carriers upon their written request or upon the recommendation of LIGHTHOUSE OPTOMETRIC VISION PERFORMANCE CENTER when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I authorize Dr. Bradford G. Murray and LIGHTHOUSE OPTOMETRIC VISION PERFORMANCE CENTER to exchange information with my child's school and other professionals involved in my child's care, by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

_____ _____

Signature Date:

_____

Relationship to Patient

I hereby give my permission to LIGHTHOUSE OPTOMETRIC VISION PERFORMANCE CENTER to treat _____ .

(Child's Name)

_____ _____

Parent's or Guardian Signature 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 of your child and to better meet your child's specific visual needs.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us.

You may leave a message for us 24 hours a day/7 days a week. To avoid a cancellation fee, we request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your child's visual status.

THANK YOU.
SINCERELY,

DR. BRADFORD G. MURRAY, O.D.