Dr. Lisa B. Dibler– OPTOMETRY - VISION THERAPY Lisa B. Dibler, O.D., LLC

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# 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**

Were you referred to our office ? Yes ☐ No ☐
If yes whom may we thank for this referral? _____ Phone: _____
Address: _____
Full Name: _____
Birth Date: _____ Age: _____years _____months

**RESPONSIBLE PERSON INFORMATION**

Home Address: _____ City:_____ Zip: _____
Home Phone: _____Cellular Phone _____email _____
Do you have Major Medical Insurance? Yes ☐ No ☐
If so, who is the carrier? _____ Policy #: _____
Name of Insured: _____ S S #_____ Group #: _____

**MEDICAL HISTORY**

Physician's Name: _____ Date of Last Evaluation: _____
For what reason? _____
Results and recommendations: _____
_____
Current state of health: _____
Medications currently using, including vitamins and supplements: _____
_____
**Why do you feel you need a vision evaluation?** _____
_____
_____

Is there any history of the following? (please check if there is a history and circle the condition

| | Patient | Family | Who | | Patient | Family | Who |
|---|---|---|---|---|---|---|---|
| High blood pressure | ☐ | ☐ | _____ | Glaucoma or eye disease | ☐ | ☐ | _____ |
| Diabetes | ☐ | ☐ | _____ | Cataracts or blindness | ☐ | ☐ | _____ |
| Thyroid Condition | ☐ | ☐ | _____ | Farsighted / nearsighted | ☐ | ☐ | _____ |
| Multiple Sclerosis | ☐ | ☐ | _____ | Amblyopia (lazy eye) | ☐ | ☐ | _____ |
| Allergies / Asthma | ☐ | ☐ | _____ | Neurological / psychological | ☐ | ☐ | _____ |

Other health problems? Yes ☐ No ☐ _____

Any history in your family of an eye turn resulting from birth, 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 there any chronic problems like ear infections, asthma, hay fever, allergies? Yes ☐ No ☐

If yes, please list: _____

List illnesses, bad falls, high fevers, accidents, hospitalizations, medical concerns, etc.:

| Age | Severe | Mild | Complications |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Have any evaluations been performed? (Neurological, psychological, educational, ) Yes ☐ No ☐

By whom? _____ Results and recommendations: _____

Has any therapy (speech and language, occupational, psychological) been undertaken? Yes ☐ No ☐

By whom? _____ Results and recommendations: _____

**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 there 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 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 ☐

**PREVIOUS TREATMENTS**

Have you 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 you have 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: _____

Do you report any of the following:

| | Yes | No | If yes, when? |
|---|---|---|---|
| Headaches | ☐ | ☐ | |
| Blurred vision | ☐ | ☐ | |
| Double vision | ☐ | ☐ | |
| Eyes "hurt" or "tired" | ☐ | ☐ | |
| Motion sickness / car sickness | ☐ | ☐ | |
| Burning, itchy, watery, red eyes | ☐ | ☐ | |

| | Yes | No | If yes, when |
|---|---|---|---|
| Bothered by light | ☐ | ☐ | |
| Frequent eye rubbing | ☐ | ☐ | |
| Squinting, struggling to see | ☐ | ☐ | |
| Closes or covers an eye | ☐ | ☐ | |
| Difficulty seeing distant objects / or near objects | ☐ | ☐ | |
| Tilts head when reading or writing or Moves head when reading | ☐ | ☐ | |
| Avoids/dislikes reading or other near tasks | ☐ | ☐ | |
| Omits / repeats small words or lines of print when reading | ☐ | ☐ | |
| Words run together when reading | ☐ | ☐ | |
| Misaligns digits / column of numbers | ☐ | ☐ | |
| Loses place when reading | ☐ | ☐ | |
| Uses finger as marker | ☐ | ☐ | |
| Poor reading comprehension | ☐ | ☐ | |
| Comprehension decreases over time | ☐ | ☐ | |
| Difficulty completing assignments on time | ☐ | ☐ | |
| Confuses / reverses letters and words | ☐ | ☐ | |

| | | | |
|---|---|---|---|
| Likes puzzles and inside games | ☐ | ☐ | _____ |
| Confuses right or left, poor with directions | ☐ | ☐ | _____ |
| Writes or prints poorly | ☐ | ☐ | _____ |
| Difficulty copying form the chalkboard | ☐ | ☐ | _____ |
| Writes up / down hill | ☐ | ☐ | _____ |
| 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 or inconsistent in sports | ☐ | ☐ | _____ |
| Difficulty hitting / catching a ball | ☐ | ☐ | _____ |

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? _____

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 and city: _____
If yes, please describe the type of visual therapy, including its duration, the age at which it started, and an estimate of the results: _____

_____

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

**RELEASE OF INFORMATION AND INSURANCE FILING**

I agree to permit information from, or copies of, my examination records to be forwarded to other health care providers or insurance carriers upon their written request or upon the recommendation of Lisa B. Dibler, O.D., LLC when it is necessary for the treatment of my visual condition, or for the processing of insurance claims. I authorize Dr. Dibler to exchange information with my doctor and other professionals involved in my care by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

_____ _____
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 for you and to better meet your 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. 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 visual status.

THANK YOU.

Sincerely,

Lisa B. Dibler, O.D.