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

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CHILDREN'S STRABISMUS QUESTIONNAIRE

Please fill out this questionnaire carefully. Please return it to our office prior to your appointment in the envelope provided. If possible, please include a recent picture of your child. 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: _____
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: _____Cellular Phone _____email _____
Other parent's home address & phone: _____
Father / Caretaker's Occupation: _____Business Phone: _____email _____
Business Address: _____ City: _____ Zip: _____
Mother / Caretaker's Occupation: _____ Business Phone: _____ email _____
Business Address: _____ City: _____ Zip: _____
Do you have Major Medical Insurance? Yes ☐ No ☐
If so, who is the carrier? _____ Policy #: _____
Name of Insured: _____ S S #_____ Group #: _____

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: _____
_____
Why do you feel your child needs 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: _____

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 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

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: _____

Do you notice or 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	☐	☐	
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: _____
_____

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: _____

SCHOOL

Age at time of entrance to : Preschool? _____ Kindergarten? _____ First Grade? _____
Describe any specific school difficulties: _____
_____
Has a grade been repeated? Why? _____
Does schoolwork seem to put undue pressure or tension on your child? Explain. _____
Has your child received any special tutoring, therapy or remedial assistance? Explain where and results _____
_____
Does your child like to read? Yes ☐ No ☐ Voluntarily? For pleasure? _____
How much time does your child spend on homework assignments? _____
To what extent do you help your child with homework? _____

Do you feel your child is achieving up to academic potential? Yes ☐ No ☐
Does your child's teacher feel he/she is achieving up to potential? Yes ☐ No ☐ Comments _____
_____

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?

RELEASE OF INFORMATION AND INSURANCE FILING

It is often beneficial to us to discuss examination results and to exchange information with your child's school, pediatrician, 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 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 child's visual condition, or for the processing of insurance claims. I authorize Dr. Dibler 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.

_____ _____

Parent's or Guardian's Signature Date

I hereby give my permission to Dr. Lisa B. Dibler to treat: _____.

(Child's Name)

_____ _____

Parent's or Guardian's 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. 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.

Please do not bring any other children with you because your undivided attention is necessary during the evaluation.

THANK YOU.

Sincerely,

Lisa B. Dibler, O.D.