



Brain & Eye Connection Vision Clinic, PC

Carolanne H. Roach, OD 1530 SW 89th St, Bldg D-2, OKC, OK 73159 (405) 703-3163
www.BrainAndEyeConnection.com Fax (405) 691-6547 visionclinic@brainandeyeconnection.com

ADULT STRABISMUS QUESTIONNAIRE

Please fill out this questionnaire *carefully*. Please return it to our office prior to your appointment in the envelope provided. Thank you.

Name of Patient: _____ Date: _____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes No If no, how long was pregnancy? _____

Did the mother experience any problems during the pregnancy? Yes No

If yes, explain: _____

Natural birth C-Section Was anesthesia used during delivery? Yes No

Were forceps used at birth? Yes No Was oxygen used after birth? Yes No

Any complications before, during or immediately following delivery? Yes No

If yes, explain: _____

Were there ever any concerns regarding growth or development? Yes No

If yes, explain: _____

VISUAL HISTORY

At what age was it first noticed or suspected 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 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 your left? Yes No

to your 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 feel your vision hinders your daily activities in any way? Yes No

If yes, explain: _____

Do you feel your vision limits your potential in any way? Yes No

If yes, explain: _____

NUTRITIONAL INFORMATION

Current Diet: Excellent Good Fair Poor

Do you: like (or) crave sweets? Yes No

Are there any indications that you have been exposed to any toxic substances or fumes?

Yes No If so, explain: _____

PREVIOUS TREATMENTS

Have you had a previous visual evaluation? Yes No

If yes, 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? Explain: _____

Are they worn? 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

Is there any other information that you feel would be helpful / important in our evaluation and/or treatment? Yes No

If yes, explain: _____

