Brain & Eye Connection Vision Clinic, PC

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CHILD STRABISMUS (EYE TURN) QUESTIONNAIRE

Please fill out this questionnaire carefully. Put N/A if not applicable or unknown.
Please return it to our office at or prior to your appointment along with the Child History Questionnaire.

At what age did you first notice or suspect that an eye was turning? ______________________
Did the eye begin turning - suddenly ☐ or gradually ☐?
Was there any related trauma, disease, or condition that preceded or accompanied the onset of the eye turn?
Yes ☐ No ☐
If yes, please explain: ______________________
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 ☐	to his/her right?	Yes ☐	No ☐
in the distance?	Yes ☐	No ☐	up?	Yes ☐	No ☐
to his/her left?	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 child's vision hinders his/her daily activities in any way? Yes ☐ No ☐
If yes, how? ______________________
Does your child wear: bifocal glasses ☐ single-vision glasses ☐ contact lenses ☐ or prisms ☐?
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: ______________________
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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: ______________________
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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: ______________________
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Is there any history in your family of an eye turn resulting from a disease or other condition? Yes ☐ No ☐
If yes, please explain: ______________________