ADULT STRABISMUS QUESTIONNAIRE

Please fill out this questionnaire carefully.
Please return it to our office prior to your appointment. 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_____
Home Address_____
Home Phone_____Cell Phone_____
Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐
Do you have Major Medical Insurance? Yes ☐ No ☐
If yes, who is the carrier?_____Policy #_____
Place of Employment & Position_____Work Phone_____
Business Address_____
Spouse's Place of Employment & Position_____Work Phone_____
Business Address_____

Please list the spouse and dependents:

NAME			
Spouse:	_____	Birth Date:	_____
Dependent:	_____	Birth Date:	_____
Dependent:	_____	Birth Date:	_____
Dependent:	_____	Birth Date:	_____
Dependent:	_____	Birth Date:	_____
Dependent:	_____	Birth Date:	_____

MEDICAL HISTORY
Physician's Name:_____Date of most recent evaluation:_____
For what problem/ condition?_____
Results and recommendations:_____
_____
Current state of health:_____
Medications currently using, including vitamins and supplements:_____
_____
For what condition(s)? _____
Are you allergic to any foods or medications? Yes ☐ No ☐
If yes, please list: _____

Is there any history of the following? (please check if there is a history)

	Patient	Family	Who
Diabetes	☐	☐	_____
Eye Turn	☐	☐	_____
Amblyopia (lazy eye)	☐	☐	_____
Blindness	☐	☐	_____
Epilepsy or Seizures	☐	☐	_____
Brain Tumor	☐	☐	_____
Eye Infections	☐	☐	_____
Glaucoma	☐	☐	_____
Cataracts	☐	☐	_____
High Blood Pressure	☐	☐	_____
Multiple Sclerosis	☐	☐	_____
Thyroid Condition	☐	☐	_____
Eye Disease	☐	☐	_____
Eye Surgery	☐	☐	_____

Any history in your family of an eye turn resulting from a disease or other condition? Yes ☐ No ☐
If yes, please explain: _____
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 you prone to infections? Yes ☐ No ☐
Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes ☐ No ☐
If yes, please list: _____
List illnesses, bad falls, high fevers, ear infections, etc.:

Age	Severe	Mild	Complications

DEVELOPMENTAL HISTORY
Full-term pregnancy? Yes ☐ No ☐
Did mother experience any problems during the pregnancy? Yes ☐ No ☐
If yes, explain: _____
Normal birth? Yes ☐ No ☐
If no, explain: _____
Were forceps used? 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: _____

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 yes, explain: _____

VISUAL HISTORY
At what age did you first notice or suspect that an eye was 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 you are looking:
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 experience any of the following:

	Yes	No	If yes, when?
Blurred vision at distance	☐	☐	_____
Blurred vision at near	☐	☐	_____
Red or itchy eyes	☐	☐	_____
Burning eyes	☐	☐	_____
Frequent Sties	☐	☐	_____
Watery eyes	☐	☐	_____
Eyes hurt	☐	☐	_____
Eyes feel tired	☐	☐	_____
Headaches	☐	☐	_____
Nausea associated with visual tasks	☐	☐	_____
Halos around lights	☐	☐	_____
Double vision at distance	☐	☐	_____
Double vision at near	☐	☐	_____
Tilt head during desk work	☐	☐	_____
Squinting, covering or closing one eye	☐	☐	_____
Postural changes when doing desk work	☐	☐	_____
Need for very bright light when reading	☐	☐	_____
Need for very dim light when reading	☐	☐	_____
Loss of interest or short attention span for close work	☐	☐	_____
Difficulty sustaining reading / writing	☐	☐	_____
General or visual fatigue at the end of the day	☐	☐	_____
Loss of place often when reading	☐	☐	_____
Skip lines when reading	☐	☐	_____
Repetition of letter or words when reading	☐	☐	_____
Omission of words when reading / copying	☐	☐	_____
Use of finger to keep place	☐	☐	_____
Head moves when reading	☐	☐	_____
Confusion of what is being seen or read	☐	☐	_____
Falling asleep when reading	☐	☐	_____
Silent vocalization/moving lips while reading	☐	☐	_____
Motion / car sickness	☐	☐	_____
Difficulty with reading comprehension	☐	☐	_____
Comprehension decreases over time	☐	☐	_____
Letters or words appear to move or float around when reading	☐	☐	_____
Difficulty aligning columns of numbers	☐	☐	_____
Can respond better orally than in writing	☐	☐	_____
Write or print poorly	☐	☐	_____
Poor time management	☐	☐	_____

Inconsistent performance in work or sports	☐	☐	_____
Poor general coordination / clumsiness	☐	☐	_____
Does not judge distances accurately	☐	☐	_____
Poor fine motor coordination	☐	☐	_____
Poor organizational skills	☐	☐	_____
Difficulties with short-term memory	☐	☐	_____
Difficulties with long-term memory	☐	☐	_____

Comments on any items above: _____
_____
_____
_____

COMPUTERS

Do you use a computer in your work, school, or leisure time activities? Yes ☐ No ☐
If so, indicate the types of computer work you perform:

- ☐ Word processing
- ☐ Programming
- ☐ Data entry
- ☐ Internet
- ☐ Games / Leisure activities
- ☐ Other (explain): _____

How many hours do you spend in front of a computer screen each day? _____
How do your eyes feel after working at the computer? _____

Where is the top of the screen located?

- ☐ Above your straight -ahead eye level
- ☐ At eye level
- ☐ Below eye level

What is the distance from:

Your eyes to the screen? _____
Your eyes to the keyboard? _____
Your eyes to your source documents? _____

Where is the computer screen located?

- ☐ Directly in front of you when seated
- ☐ To your right
- ☐ To your left

Where are your source documents located?

- ☐ Directly in front of you when seated
- ☐ To your right
- ☐ To your left
- ☐ Flat (horizontal) or vertical

Do you experience any of the following lighting problems in your work area?

- ☐ Glare from windows or other light sources
- ☐ Reflections on your computer screen
- ☐ Difficulty reading source documents

Do you wear glasses, contact lenses, or other optical devices for computer work?

☐ Glasses
☐ Contact lenses
☐ Other (explain): _____

Please describe any problems you have with your vision, current glasses or contact lenses for computer work: _____
_____
_____
_____

EMPLOYMENT OR SCHOOL

Current position: _____ Major course of study: _____
How many hours daily do you spend at a desk? _____
How many hours daily do you spend reading or studying? _____
How many hours daily do you spend working at near distances? _____
Do you feel you are achieving to your potential in work or school? Yes ☐ No ☐
Do you feel you are getting adequate return for the amount of effort you put into a task? Yes ☐ No ☐
If no, please explain: _____
Does your work or course study demand comprehension from the written word? Yes ☐ No ☐
Describe briefly your daily activities at work or in school: _____
_____

HOBBIES/SPORTS

Describe the types of activities that comprise the majority of your leisure time: _____
_____
_____

Do you watch TV? Yes ☐ No ☐
If yes, how many hours per day? _____
How many days per week? _____
Are you seriously involved with athletics? Yes ☐ No ☐
Do you feel you are achieving up to your potential in sports/athletics? Yes ☐ No ☐
Of all the sports you have played:
List the ones in which you excel: _____
List the ones in which you do poorly/avoid: _____