EagleEye VISION CARE LLC

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CHILDREN'S STRABISMUS QUESTIONNAIRE

Please fill out this questionnaire carefully. It would be helpful to receive it prior to your appointment, by mail, sent to our office, or email to info@EagleEyeVisionCare.org
THANK YOU.

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: _____ Reading Grade Level (if known): ____
Is your child especially afraid of doctors? Yes ☐ No ☐

RESPONSIBLE PERSON INFORMATION

Father/Caretaker Name: _____
Mother/Caretaker Name: _____
Home Address: _____ City: _____ Zip: _____
Home Phone: _____ Business Phone: _____
Email address: _____

Eagle Eye Vision Care LLC does not contract directly with any insurance companies. We do ask that services are paid for in full at time of service. However, we will be happy to give your insurance company the appropriate documentation that they may reimburse you at out of network rates.

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: _____
_____

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

	Patient	Family	Who		Patient	Family	Who
High blood pressure	☐	☐		Glaucoma	☐	☐	
Diabetes	☐	☐		Cataracts	☐	☐	
Thyroid Condition	☐	☐		Blindness	☐	☐	
Multiple Sclerosis	☐	☐		Amblyopia (lazy eye)	☐	☐	
Brain Tumor	☐	☐		Chromosomal Imbalance	☐	☐	

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

Age	Severe	Mild	Complications

Has a neurological evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations: _____
Has a psychological evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations: _____
Has an occupational therapy evaluation been performed? 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 ☐
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 was an eye turning? _____
Did the eye begin turning - <u>suddenly</u> ☐ or <u>gradually</u> ☐?
Does the eye turn - <u>in</u> ☐ <u>out</u> ☐ <u>up</u> ☐ or <u>down</u> ☐? (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 ☐
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	☐	☐	_____
Redness of the eyes	☐	☐	_____

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? _____

Have you or anyone else ever noticed the following:

	Yes	No	If yes, when?
Eyes frequently reddened	☐	☐	
Frequent eye rubbing	☐	☐	
Frequent sties	☐	☐	
Frowning	☐	☐	
Bothered by light	☐	☐	
Closes or covers an eye	☐	☐	
Difficulty seeing distant objects	☐	☐	
Head close to paper when writing	☐	☐	
Avoids/dislikes reading or other near tasks	☐	☐	
Tilts head when reading or writing	☐	☐	
Moves head when reading	☐	☐	
Confuses letters and words	☐	☐	
Reverses letters or words	☐	☐	
Confuses right or left	☐	☐	
Skips, omits words	☐	☐	
Loses place when reading	☐	☐	
Uses finger as marker	☐	☐	
Poor reading comprehension	☐	☐	
Comprehension decreases over time	☐	☐	
Writes or prints poorly	☐	☐	
Difficulty copying from the chalkboard	☐	☐	
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 sports	☐	☐
Difficulty hitting/catching a ball	☐	☐

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: _____

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: _____

_____

RELEASE OF INFORMATION

We fully comply with the Health Insurance Portability and Accountability Act (HIPPA) and a full copy of the rules and regulations is available at your request. 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 the EAGLE EYE VISION CARE LLC when it is necessary for the treatment of my child's visual condition. I authorize Dr. Eagles and the Eagle Eye Vision Care 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 Eagle Eye Vision Care 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.

If necessary, you are welcome to bring siblings to the evaluation. Keep in mind, however, that other children may be a distraction for you and the patient, this may reduce the efficiency of the evaluation.

THANK YOU.

Sincerely,

Keirsten D. Eagles, O.D., M.Ed.