Center for Vision & Learning

CHILD STRABISMUS (EYE TURN) QUESTIONNAIRE

IMPORTANT: Please fill out this page only if your child has been previously diagnosed with an eye turn, or if you or someone you know suspects that your child has an eye turn. If neither applies to your child, you may skip this section.

What is your biggest concern about the eye turn? ____

____

Who first noticed/suspected the eye turn? __________________ When? __________________

Does one pupil ever appear to be larger than the other? □ NO □ YES

Do you ever notice one or both eyes shaking rapidly? □ NO □ YES

What was the onset of the eye turn? □ Sudden □ Gradual

If sudden, is there a specific incident (e.g. trauma or illness) that occurred right before the eye(s) began to turn? ______

____

The eye turn is... □ Getting better. □ Getting worse. □ Staying the same.

Does your child ever report seeing double? □ NO □ YES

If yes, does your child notice if the double vision is worse when he/she looks:

Up? □ NO □ YES

Down? □ NO □ YES

To your left? □ NO □ YES

To your right? □ NO □ YES

Up close? □ NO □ YES

In the distance? □ NO □ YES

Does your child have a consistent head turn? □ NO □ YES

If yes, which direction? □ Right □ Left □Up □ Down

Does your child have a consistent head tilt (e.g. ear to shoulder)? □ NO □ YES

If yes, which direction? □ Right □ Left

In which direction does the eye turn? (Check all that apply) □ In □ Out □ Up □ Down

Is it always the same eye that turns? □ NO □ YES

If yes, which eye? □ Right □ Left

Is the eye turn always present? □ NO □ YES

If not, under what condition is it present (e.g. tired, ill, emotional)? ______________________________

____

Date: ___/___/___ Doctor's Initials: ______

Center for Vision & Learning • Matthew Walsh, O.D., FCOVD
728 Tamiami Trail North, Naples, FL 34102 • 239-682-0945 • Fax: 1-888-977-1278
WWW.NAPLESVISIONTHERAPY.COM • INFO@NAPLESVISIONTHERAPY.COM

CENTER FOR VISION & LEARNING

Do you notice if the eye turns more when your child is looking:

Up?	□ NO	□ YES	
Down?	□ NO	□ YES	
To his/her left?	□ NO	□ YES	
To his/her right?	□ NO	□ YES	
Up close?	□ NO	□ YES	
In the distance?	□ NO	□ YES	
Have you ever been told that your child has amblyopia ("lazy eye")?	□ NO	□ YES	
Does the eye turn less when glasses or contact lenses are worn?	□ NO	□ YES	□ UNSURE
Has there been any treatment using an eye patch?	□ NO	□ YES	

If yes, please describe when the patching was started, how much patching was done, the age it started, the eye patched, the duration of treatment, and an estimation of the results: ______________________________

____

Has there been any surgical treatment? □ NO □ YES

If yes, by whom? ______________________________

If yes, please describe the surgery, the age when it was performed, the number of operations, the eye operated on, and an estimation of the cosmetic and subjective results: ______________________________

____

____

Were you satisfied with the results of the surgery? □ NO □ YES

Please explain: ______________________________

Was the surgeon satisfied with the results of the surgery? □ NO □ YES

Please explain: ______________________________

Has there been any optometric vision therapy? □ NO □ YES

If yes, by whom? ______________________________

Please describe the type of vision therapy, age at which it was started, duration, and an estimation of the results:

____

____

Are you here for a second opinion regarding surgery or further treatment? □ NO □ YES

IF AVAILABLE, COLLECT SEVERAL PHOTOS OF YOUR CHILD WHERE THE EYE TURN IS PRESENT AND BRING THEM WITH YOU TO THE EVALUATION. IT IS BEST IF THE PHOTOS ARE OF VARIOUS AGES AND THE CHILD IS LOOKING DIRECTLY AT THE CAMERA.

Date: ___/___/___ Doctor's Initials: ______

CENTER FOR VISION & LEARNING • MATTHEW WALSH, O.D., FCOVD
728 TAMIAMI TRAIL NORTH, NAPLES, FL 34102 • 239-682-0945 • FAX: 1-888-977-1278
WWW.NAPLESVISIONTHERAPY.COM • INFO@NAPLESVISIONTHERAPY.COM