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Strabismus History

Please answer each question carefully. It is often helpful to consult photographs from age 6 - 36 months and bring them to the examination for review by the doctor.

What are the main concerns (depth perception, cosmetic appearance, reduced eyesight (amblyopia), etc.)?_____

_____

At what age did you first notice or suspect that an eye was turning? _____

Did the eye begin turning - suddenly ☐ or gradually ☐?

Has the eye turn gotten better or worse in magnitude and/or frequency since the onset? _____

Is there a family history of an eye turn? Yes ☐ No ☐ Unsure ☐ Whom? _____

Was it the result of an injury or illness? Yes ☐ No ☐ Unsure ☐ Explain: _____

Were there any associated symptoms (fever, ear infections, double vision)? _____

Does the eye turn - in ☐ out ☐ up ☐ or down ☐? (check all that apply)

Is it always the same eye that turns? Yes ☐ No ☐ If yes, which eye? Right ☐ Left ☐ Alternates ☐

Is the eye turn always present? Yes ☐ No ☐ Unsure ☐

If not, under what conditions is it present? (i.e. when tired, when ill, etc.) _____

Do you notice if the eye turns more when looking:

up close? Yes ☐ No ☐ in the distance? Yes ☐ No ☐
to the left? Yes ☐ No ☐ to the right? Yes ☐ No ☐
up? Yes ☐ No ☐ down? Yes ☐ No ☐

Does the eye turn less when glasses are worn? Yes ☐ No ☐ Unsure ☐

Does one pupil ever appear to be larger than the other? Yes ☐ No ☐ Which? Right ☐ Left ☐ Alternates ☐

Do you ever notice one or both eyes shaking rapidly? Yes ☐ No ☐

Has amblyopia ("lazy eye") ever been diagnosed? Yes ☐ No ☐

Has there been any treatment using an eye patch? Yes ☐ No ☐

If yes, please describe when the patching was started (including the age it started), how the patching was done, the eye patched, the duration of treatment, any patient resistance, and an estimate of the results: _____

_____

_____

Has there been any surgical treatment? Yes ☐ No ☐ If yes, please list number of surgeries _____

If yes, please describe the direction of the eye turn before surgery, the age surgery was performed, the eye(s) operated on, and an estimate of the cosmetic and subjective results (continue on back if necessary):

	Eye turn before surgery	Age	Eye(s) operated on	Estimate of the cosmetic and subjective results
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

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 vision therapy? Yes ☐ No ☐ If yes, Drs. name: _____

If yes, please describe the type of vision therapy, the age at which it started, duration of treatment, and an estimate of the results: _____

_____

_____

Reviewed _____