New England College of Optometry
CENTER FOR EYE CARE

# ADULT STRABISMUS QUESTIONNAIRE

***Please fill out this questionnaire and return it to the clinic prior to your appointment.***

**GENERAL INFORMATION**

Patient's Name: _____ Gender: _____
Birth Date: _____ Age: _____
Home Address: _____City/State:_____ Zip: _____
Home Phone: _____ Work Phone:_____
Cell Phone: _____
Email: _____
Social Security Number: _____ Driver's License No.:_____
Marital status: _____ Occupation: _____
Employer: _____ Business Phone: _____
Business Address: _____ City/State: _____ Zip: _____
Spouse/Partner's Name: _____ Cell Phone: _____
Spouse/Partner's Occupation: _____
Spouse/Partner's Employer: _____ Business Phone: _____
Business Address: _____ City/State: _____ Zip: _____

Whom may we thank for this referral? _____
Address: _____ Phone: _____

**MEDICAL HISTORY**

Physician's Name:_____ Date of Last Evaluation: _____
For what problem/condition? _____
Results and recommendations: _____
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: _____
Current diet restrictions and/or concerns:_____
_____
Current state of health/any concerns (explain): _____
_____
Any history in your family of an eye turn resulting from a disease or other condition? 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: _____

Have you had any head traumas or accidents? Please describe _____

_____

_____

_____

Were any of these head traumas or accidents work-related? _____

List illnesses, bad falls, high fevers, ear infections, etc.:

Age Severe Mild Complications

_____

_____

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

| | Patient | Family | Who | | Patient | Family | Who |
|---|---|---|---|---|---|---|---|
| Diabetes | ☐ | ☐ | _____ | High Blood Pressure | ☐ | ☐ | _____ |
| Blindness | ☐ | ☐ | _____ | Eye Infections | ☐ | ☐ | _____ |
| Eye Turn | ☐ | ☐ | _____ | Thyroid Condition | ☐ | ☐ | _____ |
| Glaucoma | ☐ | ☐ | _____ | Eye Surgery | ☐ | ☐ | _____ |
| Cancer | ☐ | ☐ | _____ | Cataracts | ☐ | ☐ | _____ |
| Multiple Sclerosis | ☐ | ☐ | _____ | Lazy Eye | ☐ | ☐ | _____ |
| Brain Tumor | ☐ | ☐ | _____ | Eye Disease | ☐ | ☐ | _____ |

**Please include copies of all the tests and evaluations that have been completed:**

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 neuropsychological testing been performed? Yes ☐ No ☐

By whom? _____ Results and recommendations: _____

_____

Has an occupational therapy, physical therapy or speech/language evaluation been performed?

Yes ☐ No ☐ By whom? _____ Results and recommendations: _____

_____

**VISUAL HISTORY**

At what age was it first noticed or suspected 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 no, under what conditions is it present? _____

Does the eye always turn the same amount? Yes ☐ No ☐

If no, explain: _____

Do you notice if the eye turns more when you look:

- 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 ☐

**PRESENT SITUATION**

Why do you feel the need for a visual evaluation? _____

_____

How long has this problem/difficulty existed? _____

Do you experience any of the following:

| | Yes | No | If yes, when? |
|---|---|---|---|
| Headaches | ☐ | ☐ | |
| Blurred vision | ☐ | ☐ | |
| Double vision | ☐ | ☐ | |
| Eyes tired | ☐ | ☐ | |
| Eyes hurt | ☐ | ☐ | |
| Motion sickness/car sickness | ☐ | ☐ | |
| Frequent sties | ☐ | ☐ | |
| Red or bloodshot eyes | ☐ | ☐ | |
| Watery eyes | ☐ | ☐ | |
| Bothered by light | ☐ | ☐ | |
| Closing or covering an eye to see better | ☐ | ☐ | |
| Need to hold paper close when reading or writing | ☐ | ☐ | |
| Head tilt | ☐ | ☐ | |
| Confusion of letters or words | ☐ | ☐ | |
| Skipping or omitting words | ☐ | ☐ | |
| Loss of place when reading | ☐ | ☐ | |
| Need to use finger to keep place | ☐ | ☐ | |
| Poor reading comprehension | ☐ | ☐ | |
| Comprehension decreases over time | ☐ | ☐ | |
| Write or print poorly | ☐ | ☐ | |
| Fatigue easily | ☐ | ☐ | |
| Difficulty with short term memory | ☐ | ☐ | |
| Difficulty with long term memory | ☐ | ☐ | |
| Short attention span/loss of interest | ☐ | ☐ | |
| Difficulty attending to details | ☐ | ☐ | |
| Poor/awkward general motor coordination | ☐ | ☐ | |
| Poor fine motor coordination | ☐ | ☐ | |
| Difficulty judging distances | ☐ | ☐ | |
| Difficulty driving | ☐ | ☐ | |
| Dislike/avoid sports | ☐ | ☐ | |
| Difficulty hitting or judging moving targets during sports | ☐ | ☐ | |

List any other complaints you have concerning vision: _____

_____

Do you feel your vision hinders your daily activities in any way? Yes ☐ No ☐
If yes, explain: _____
Do you feel your vision limits your potential in any way? Yes ☐ No ☐
If yes, explain: _____

**PREVIOUS TREATMENTS**

Have you had a previous visual evaluation? Yes ☐ No ☐
If yes, doctor's name: _____ Date of last evaluation: _____
Results and recommendations: _____
Were glasses, contact lenses, or other optical devices recommended or prescribed? Yes___ No____
If yes, bifocal? ☐ single vision? ☐ contact lenses? ☐ Other? ☐ Explain: _____
Are they worn? Yes ☐ No ☐
If yes, when? _____
If no, why not? _____
Does the eye turn less when the prescription is worn? Yes ☐ No ☐ Unsure ☐
Have you been told that you have amblyopia (lazy eye)? Yes ☐ No ☐
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: _____

_____

_____

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(s) operated on, and an estimate of the cosmetic and subjective results: _____

_____

_____

Was the surgeon satisfied with the results of surgery? Yes ☐ No ☐ Explain: _____

_____

Were you satisfied with the results of surgery? Yes ☐ No ☐ Explain: _____

_____

Have surgical results been maintained? Yes ☐ No ☐ Explain: _____

_____

Has there been any visual therapy? Yes ☐ No ☐
If yes, doctor's name: _____
Please describe the type of visual therapy, including duration, the age at which it started and an estimate of results: _____

_____

Are you here for a second opinion regarding surgery or other treatment? Yes ☐ No ☐

**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 spent in front of a computer screen each day? _____
How many hours do you spend using a smart phone/tablet each day? _____
How do your eyes feel after working at the computer/smart phone/tablet? _____
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? _____
Are you achieving up 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 ☐
Does your work or course of study demand comprehension from the written word? Yes ☐ No ☐
Describe briefly your daily activities at work or in school: _____

_____

_____

**HOBBIES/LEISURE TIME**

Describe the types of activities that comprise the majority of your spare 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 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: _____
Do you feel your vision limits or prevents you from participating in any activities? Yes ☐ No ☐

If so, explain what and how: _____

Is there any other information that you feel would be helpful/important in our evaluation and/or treatment? Yes ☐ No ☐
If yes, explain: _____

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 and to better meet your specific visual needs. If you would like to communicate via email, please complete the Authorization to Email Protected Health Information form located on the website. Completed questionnaires can be mailed or faxed to:

NECO Center for Eye Care
930 Commonwealth Ave.
Boston, MA 02215
Fax: 617-396-8517

If at any time you have any questions or concerns regarding your vision or treatment, please do not hesitate to contact us.

We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your evaluation so that we may have the maximum opportunity to evaluate your visual status.

Thank you.

Sincerely,

Celia Hinrichs, O.D., FCOVD
Gayathri Srinivasan, OD, MS, FAAO