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Strabismus History Supplement

***Fill out this form if you or your child has ever been diagnosed with strabismus (eye turn). If you are unsure, please call our office at 512.501.2100. Thank you!**

Patient's Name: _____ **Birth Date:** _____

STRABISMUS HISTORY

At what age did you first notice or suspect that there was an eye 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 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 one pupil ever appear to be larger than the other? Yes ☐ No ☐

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

Have you ever been told that your child has amblyopia ("lazy eye")? Yes ☐ No ☐

PREVIOUS TREATMENTS

Has there been any treatment using an eye patch? Yes ☐ No ☐
If yes, please describe when the patching was started, the eye patched, the duration of treatment, and an estimate of the results: _____

_____

Has there been any surgical treatment? Yes ☐ No ☐ If yes, surgeon's name: _____
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 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: _____

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

_____

Were you satisfied with the results of vision therapy? Yes ☐ No ☐
Please explain: _____
Was the doctor satisfied with the results of vision therapy? Yes ☐ No ☐
Please explain: _____