ORANGEVILLE VISION DEVELOPMENT CENTRE

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Strabismus and Amblyopia [Child]

PATIENT INFORMATION

Name: _____ ☐ Male ☐ Female

Date of Birth: _____ (M/D/Y) Age: _____ Home Phone: _____

Address: _____

City: _____ Postal Code: _____

Parent's Names _____ & _____

Parent's Cell Number _____ & _____

Email: _____ Referred by: _____

Health Card #: _____ VC_____

Last Eye Exam: _____ Optometrist: _____

Optometrist's Phone Number:_____ Fax Number:_____

Grade: _____ School: _____

Individualized Education Program: ☐ **Yes** ☐ **No**

HEATH HISTORY

Family Doctor: _____

Family Doctor's Phone Number:_____ Fax Number:_____

Please list any current medical conditions: _____

Past surgical history: _____

Medications: _____

Allergies: _____

Is your child generally healthy? ☐ **Yes** ☐ **No**

Is there a history of bad fall(s) that resulted in a head injury? ☐ **Yes** ☐ **No**
If Yes, was it considered Mild, Moderate or Severe: _____

Is there a history of high fevers? ☐ **Yes** ☐ **No**
If Yes, was it considered Mild, Moderate or Severe: _____

What was the frequency of the fevers? _____

Is there a history of chronic ear infections? ☐ **Yes** ☐ **No**
If Yes, was it considered Mild, Moderate or Severe: _____

Did your child have tubes put in? ☐ **Yes** ☐ **No**

Did your child have surgery to treat the ear infections? ☐ **Yes** ☐ **No**

Has any neurological and/or psychological evaluation been performed?

- ☐ Yes
- ☐ No

Any current or past Occupational, Physical and/or Speech Therapy?

- ☐ Yes
- ☐ No

Is your child performing below, above or at grade level for knowing numbers/letters, writing and reading? _____

_____

OCULAR HISTORY

Any history of the following?	Patient	Family	COMMENT
Eye Turn (Strabismus)	☐	☐	_____
Lazy Eye (Amblyopia)	☐	☐	_____
Double Vision (Diplopia)	☐	☐	_____
High Prescription	☐	☐	_____
Learning Disabilities	☐	☐	_____
Eye Shake (Nystagmus)	☐	☐	_____
ADD/ADHD	☐	☐	_____
Autism	☐	☐	_____

Does the patient wear glasses?

- ☐ Yes
- ☐ No

If Yes, at what age was the first pair of glasses prescribed?

_____

Are the glasses worn part time or full time?

- ☐ Part time
- ☐ Full time

The glasses are worn to correct…

- ☐ Near Vision
- ☐ Distance Vision
- ☐ Both

Are there prisms in the current glasses?

- ☐ Yes
- ☐ No

EYE TURN HISTORY

At what age did the eye turn start?

_____

Is there a history of wearing an eye patch as prescribed by a professional?

- ☐ Yes
- ☐ No

If YES, how many hours a day was the patch worn?

_____

How many times a week?

_____

Is the patient seeing an eye surgeon/ophthalmologist? Who?

_____

What are the results/ recommendations by the ophthalmologist?

_____

Has the patient had eye muscle surgery? If Yes, when?

_____

How long after the last surgery did the eye begin turning again?

_____

Which eye is turning?

_____

Does the eye turn in, out, up or down?

_____

SYMPTOMS

Physical Signs / Complaints	YES	NO	COMMENT
Bumps into objects/clumsy	☐	☐	_____
Avoidance/poor focus with near work/reading	☐	☐	_____
Headaches around eyes/forehead	☐	☐	_____
Head turn or tilt	☐	☐	_____
Hold reading material too close	☐	☐	_____
Skips words or lines when reading	☐	☐	_____
Trouble catching a ball	☐	☐	_____
Closes/covers an eye during deskwork	☐	☐	_____
Difficulty judging distances	☐	☐	_____

DEVELOPMENTAL HISTORY

Did mother experience any health problems during the pregnancy? ☐ **Yes** ☐ **No**
If YES, please explain: _____

Were there any complications with the birth? ☐ **Yes** ☐ **No**
If YES, please explain: _____

Was the child born premature? ☐ **Yes** ☐ **No**
If yes, what was the length of pregnancy? _____

Did your child crawl? ☐ **Yes** ☐ **No**
What type of crawl did your child do?
☐ Stomach on floor ☐ On all fours ☐ Bum scooted

At what age did your child walk? _____

Were there any early behavioral problems (temper tantrums, self-destructive behavior, difficulty sleeping, skipped crawling, toe walking etc.)? ☐ **Yes** ☐ **No**
If yes, please explain: _____

Any current or past speech problems: ☐ **Yes** ☐ **No**
What age did your child say their first word? _____
Was early speech clear to others? _____
Is speech clear now? ☐ **Yes** ☐ **No**

Receiving any special development assistance? ☐ OT ☐ PT ☐ Speech Other_____

If ADD/ADHD or a Learning Disability or Dyslexia was diagnosed, who diagnosed it, how was it diagnosed and when?

_____
_____

SCREEN TIME

Does your child watch television? ☐ **Yes** ☐ **No**
How many hours a week does your child watch television? _____

Does your child play video games? ☐ **Yes** ☐ **No**
How many hours a week does your child play video games? _____

Does your child use a smartphone/tablet? ☐ **Yes** ☐ **No**
How many hours a week does your child spend on the smartphone/ tablet? _____
How is your child likely to use the smartphone/tablet? (Please circle all that apply)
☐ Play games ☐ Watch videos ☐ Social media ☐ Other

Please list all extra-curricular activities your child is currently engaged in (sports, swimming, music, gymnastics, dance etc.)

_____ Hours per week: _____
_____ Hours per week: _____
_____ Hours per week: _____

OBSERVATIONS

Physical Signs / Complaints	**YES**	**NO**	**COMMENT**
Headaches, especially after near work	☐	☐	_____
Exhausted after day of school	☐	☐	_____
Car sickness	☐	☐	_____
Blurry vision, even with glasses	☐	☐	_____
Frequently rubs eyes	☐	☐	_____
Turns head to side when watching TV	☐	☐	_____
Tilts or turns head during deskwork	☐	☐	_____
Closes/covers an eye during deskwork	☐	☐	_____
Head gets close to reading material	☐	☐	_____

Reading	**YES**	**NO**	**COMMENT**
Words run together, move, or double when reading	☐	☐	_____
Skips, repeats lines when reading	☐	☐	_____
Uses finger to maintain place	☐	☐	_____
Omits words when reading	☐	☐	_____
Slow reader compared to peers	☐	☐	_____
Difficulty reading words (decoding)	☐	☐	_____
Tires rapidly and loses attention when reading	☐	☐	_____
Poor comprehension	☐	☐	_____
Dislikes chapter books	☐	☐	_____
Reads well for short time, then slows	☐	☐	_____

Writing / Drawing	**YES**	**NO**	**COMMENT**
Difficulty copying from board	☐	☐	_____
Copying takes longer than normal	☐	☐	_____
Copies words backwards	☐	☐	_____
Reverses numbers, letters, or words	☐	☐	_____
Writes up/ down hill	☐	☐	_____
Misaligns digits/columns of numbers	☐	☐	_____
Poor pencil grip	☐	☐	_____

Mathematics	**YES**	**NO**	**COMMENT**
Difficulty learning to count	☐	☐	_____
Poor memory for numbers	☐	☐	_____
Difficulty with math problem-solving skills	☐	☐	_____
Difficulty reading clocks with hands	☐	☐	_____

Attention	**YES**	**NO**	**COMMENT**
Attention better when listening rather than reading	☐	☐	_____
Constantly fidgets	☐	☐	_____
Homework is a battle; can’t concentrate	☐	☐	_____
Poor eye contact; appears to not be listening	☐	☐	_____
Can’t locate belongings/ things or forgets	☐	☐	_____

Behaviour	**YES**	**NO**	**COMMENT**
Does not socialize well with other children	☐	☐	_____
Does not like going to school	☐	☐	_____
Difficult to discipline at home	☐	☐	_____
Poor organizational skills	☐	☐	_____
Easily distracted	☐	☐	_____
Anxious frequently	☐	☐	_____
New situations/events (transitions) difficult	☐	☐	_____
Under fatigue/stress, child withdraws	☐	☐	_____
Frequently says “I can’t” before trying	☐	☐	_____
Feels “stupid,” poor confidence	☐	☐	_____

Coordination	**YES**	**NO**	**COMMENT**
Clumsy, poor balance	☐	☐	_____
Falls frequently or trips	☐	☐	_____
Often knocks things over, esp. at table (messy eater)	☐	☐	_____
Difficulties learning bike riding	☐	☐	_____
Can’t keep eye on ball, or hit a ball (catching, batting)	☐	☐	_____
Reads a lot, avoids exercise	☐	☐	_____
Difficulty with puzzles	☐	☐	_____

FAMILY & HOME

Please indicate who your child lives with: (Please circle all that apply)

☐ Mother ☐ Father ☐ Siblings ☐ Stepmother ☐ Stepfather
☐ Adoptive Parents ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle
☐ Foster Parents
☐ Other caretaker (please specify): _____

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? _____
If YES, at what age did it occur? _____

Did the father or anyone in the father’s family have a learning problem? ☐ **Yes** ☐ **No**
If YES, who? _____

Did the mother, or anyone in the mother’s family have a learning problem? ☐ **Yes** ☐ **No**
If YES, who? _____

Do any, or did any, of the other children in the family have a learning problem? ☐ **Yes** ☐ **No**
If YES, Who? _____

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☐ **I DO NOT GIVE** ORANGEVILLE VISION DEVELOPMENT CENTRE PERMISSION TO EMAIL ME WITH MEDICAL REPORTS, EDUCATION, PERSONAL COMMUNICATIONS & PROMOTIONS

_____ _____
Signature Date