INSPIRE
VISION DEVELOPMENT CENTRE
DR. PATEL & ASSOCIATES

STRABISMUS & AMBLYOPIA RELATED VISION PROBLEMS

PATIENT INFORMATION

Name: _____ ⬜ Male ⬜ Female

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

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Referred by: _____

Health Card #: _____ Version Code: _____

Last eye exam: _____ Optometrist: _____

HEALTH HISTORY

Please list any head injuries, illness, and any chronic problems:_____

_____

Family Doctor: _____

Past surgical history: _____

Medications: _____

Allergies: _____

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	☐	☐	_____

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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

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