ORANGEVILLE VISION DEVELOPMENT CENTRE
DR. PATEL & ASSOCIATES

310 Broadway Avenue
Orangeville, Ontario
L9W 1L3
Tel: 519-940-8426
Fax: 519-341-1648
reception@ovdc.ca

Strabismus and Amblyopia [Child]

PATIENT INFORMATION

Name: _____ ⬜ Male ⬜ Female ⬜ Other _____

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: _____ Phone: _____ Fax: _____

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? ⬜ Yes ⬜ No If Yes, when? _____

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

Which eye is turning? ⬜ Right ⬜ Left ⬜ Both ⬜ No Sure

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

DEVELOPMENTAL HISTORY

Did the 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 the early speech clear to others? ⬜ **Yes** ⬜ **No**
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?

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	⬜	⬜	_____
Difficulty judging distances	⬜	⬜	_____

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	☐	☐	_____
Avoidance/poor focus with near work/reading	☐	☐	_____
Hold reading material too close	☐	☐	_____

Writing / Drawing	**YES**	**NO**	**COMMENT**
Difficulty copying from board or 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	⬜	⬜	_____

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 extracurricular activities your child is currently engaged in (sports, swimming, music, gymnastics, dance etc.)

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

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)? ⬜ **Yes** ⬜ **No**
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? _____

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

_____ _____
Signature Date