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 & AMBLYOPIA RELATED VISION PROBLEMS

PATIENT INFORMATION

Name: _____ ⬜ Male ⬜ Female ⬜ Other _____

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	☐	☐	_____

⬜ **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