Justin Chelette, OD FAAO
Developmental Optometrist

STRABISMUS / AMBLYOPIA INTAKE FORM (completed in addition to the adult or child intake form)

Full Name: ____ Male ☐ Female ☐
Birth Date: ____ Age: _______

OCULAR HISTORY

At what age did you first notice or suspect an eye turn? ____________________________________

Did the eye begin turning: ☐ suddenly ☐ gradually

Does the eye turn (check all that apply): ☐ in ☐ out ☐ up ☐ down

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 you or your child is 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

PREVIOUS TREATMENTS

Have you or your child had a previous visual evaluation? ☐ Yes ☐ No

Doctor's Name: ______________________________________ Date of Last Visit: ______________

Results and recommendations: ____

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Wear glasses, contact lenses, or other optical devices? ☐ Yes ☐ No

If yes: ☐ Bifocal ☐ Single-vision ☐ Contact lenses ☐ Other explain: ____________________

Are they used? ☐ Yes ☐ No

Does the eye turn less when the prescription is worn? ☐ Yes ☐ No ☐ Unsure

Has there been any treatment using an eye patch? ☐ Yes ☐ No

If yes, please describe when the patching was started, how the patching was done, including the age it was started, the eye patched, the duration of treatment, and an estimate of the results:

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Has there been any surgical treatment? ☐ Yes ☐ No

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 cosmetic and subjective results:

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Were you satisfied with the results of surgery? ☐ Yes ☐ No

Please explain:

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Are you here for a second opinion regarding surgery or further treatment? ☐ Yes ☐ No

Has there been any visual therapy? ☐ Yes ☐ No

If yes, Drs. name:

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If yes, please describe the type of visual therapy, including its duration, the age at which it started, and an estimate of the results:

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