Drs. Fine, Hoffman & Sims
OPHTHALMOLOGISTS

Dr. Sabah's Strabismus History Form **Patient:**_____

General reason for strabismus evaluation: **DOB:**_____

- Briefly state the reasons for which you are bringing your child to the eye doctor?

_____

- Does your child have trouble seeing? If yes, is it more for near or far?

_____

- Does your child turn or tilt his/her head in an unusual fashion? yes no
If so, explain.

_____

- If your child has crossing or drifting of the eyes, please answer the following:

When did it first appear? _____

-Which eye is affected? Circle please: Right Left Both

-How often is it present? Constantly? Intermittently?

-What treatment has been used? Glasses? Bifocals?

-Patching? If yes, still patching? yes no

-When did she/he last patch? _____ How many hours? _____

-Any eye surgery? If yes, when and what was done?

Prenatal history:

-Maternal chlamydia? yes no

-Maternal HSV? yes no

-Maternal rubella? yes no

-Maternal syphilis? yes no

-Maternal HIV? yes no

-Infection during pregnancy? yes no

-Substance use during pregnancy? yes no

If yes, which one? _____

-Maternal medical problems? Please describe: _____

Birth history:

- Birth weight? _____

-Passed hearing exam ? yes no

-Delivery type - Circle all that apply:

Vaginal With forceps With suction cup C-section

-Gestational age at delivery (in weeks)? _____

-Problems after delivery? yes no

- Did your child require oxygen? yes no
If yes, for how long? _____

- Did she/he begin to breathe and eat normally? yes no

- Was amniocentesis performed during pregnancy? yes no

Development:

- Age child could first sit? _____

- Age child could first stand? _____

- Age child began to walk? _____

- Is your child's growth and development normal? yes no

- How is your child's motor coordination? _____

- How is your child doing in school? _____

- School grade? _____

Past medical history:

- Any history of:
* Cerebral palsy? yes no

* Developmental delays? yes no

* Seizures? yes no

* Congenital heart diseases? yes no

* Serious injury? yes no

* other problems with ears, nose, throat, lungs, gastrointestinal, urogenital system, skin, endocrine, blood or psychiatric? yes no

Family history:

- Is there anyone in your family with a history of:
* A condition similar to your child's? yes no

* Crossed, wandering or lazy eye? yes no

* Adverse reaction to anesthetic? yes no

* Any other serious eye disease not correctable with glasses? yes no

Home/family:

-Guardian? Biological parent Foster parent other: _____

-History of neglect? yes no

-History of accidental trauma? yes no

Health Status:

-Recent ER visit? yes no

-Recent hospitalizations? yes no

If so, reason and discharge diagnosis:

_____

-Current hearing status? Normal Abnormal, specify:_____

Person completing form **Relationship to patient** **Date**

*****Scan to visit in EHR after appointment.*****