ALDERWOOD VISION THERAPY CENTER, PLLC
Drs. Torgerson, Murphy, Maher, & Hash
16006 Ash Way, #101, Lynnwood, WA 98087 (425) 787-5200

Dr. Initials/Date: _____ /_____

SUPPLEMENTAL AMBLYOPIA AND STRABISMUS QUESTIONNAIRE

Appointment Date: ____ /____ /____

Full Legal Name: _____ Date of Birth: ____ /____ /____ Age: _____

HISTORY OF AMBLYOPIA *(If applicable)*
Is there a family history of decreased vision resulting from a disease or other condition? Yes ☐ No ☐
If yes, please explain: _____

Was there any related trauma, disease, or condition that preceded or accompanied the onset of decreased vision? Yes ☐ No ☐ If yes, please explain: _____
Is vision decreased despite an updated spectacle or contact lens prescription? Yes ☐ No ☐

At what age was amblyopia diagnosed? _____ Was vision loss gradual or sudden? _____
In which eye is the amblyopia?
☐ Right Eye
☐ Left Eye
☐ Both

Is there an eye turn associated with the amblyopia? Yes ☐ No ☐

Has treatment in the form of patching or eye drops ever been administered? Yes ☐ No ☐
If yes, please explain: _____
Who provided this treatment plan? Doctor's Name:_____ City:_____
May we request records from this doctor? Yes ☐ No ☐

Method of Patching: _____
Eye that was being patched: ☐ Right Eye ☐ Left Eye Hours patched per day: _____
Age at which treatment was started: _____ Age at which treatment was stopped: _____
Were you satisfied with the results of this therapy? Yes ☐ No ☐
Were you or your child resistant to patching? Yes ☐ No ☐
Were any improvements noted? Yes ☐ No ☐ Explain: _____

HISTORY OF STRABISMUS *(If applicable)*
Is there a family history of an eye turn resulting from a disease or other condition? Yes ☐ No ☐
If yes, please explain: _____
Are there any other health problems? Yes ☐ No ☐
If yes, please explain: _____

Was there any related trauma, disease, or condition that preceded or accompanied the onset of the eye turn? Yes ☐ No ☐ If yes, please explain: _____
At what age did you first notice or suspect there was an eye turning? _____

Did the eye begin turning suddenly or gradually? Sudden ☐ Gradual ☐
Which eye is turning?
☐ Right Eye
☐ Left Eye
☐ Both

In which direction does the eye turn? Please select all that apply below:
☐ Up
☐ Down
☐ In
☐ Out
☐ Rotates

Is it always the same eye that turns? Yes ☐ No ☐
Is the eye turn constant? Yes ☐ No ☐
If no, please explain under which conditions the turn is present (i.e. when tired, ill)
_____

Is the eye turn getting worse or better, or is there no change? _____

Do you notice if the eye turns more when looking:

Up close?	Yes ☐	No ☐
In the distance?	Yes ☐	No ☐
To your left?	Yes ☐	No ☐
To your 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 (nystagmus)? Yes ☐ No ☐
Is there a current glasses prescription being worn? Yes ☐ No ☐
Does the eye seem to turn less with the glasses on? Yes ☐ No ☐ Unsure ☐

Has there been any surgical treatment? Yes ☐ No ☐
Who provided this surgical treatement? Doctor's Name:_____ City:_____
May we request records from this doctor? Yes ☐ No ☐

Please describe the surgery, including the age surgery was performed, the number of operations, the eye operated on, and results:
_____
_____
_____
_____

Were you satisfied with the results of surgery? Yes ☐ No ☐
Please explain: _____
Was the surgeon satisfied with the results of surgery? Yes ☐ No ☐
Please explain: _____

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

Has there been any vision therapy? Yes ☐ No ☐
If yes, Doctor's Name:_____ City: _____
May we request records from this doctor? Yes ☐ No ☐

Please describe the type of therapy, including duration, age at which it started, and estimate of the results: _____

_____

_____

_____

What are your vison goals? Please explain:

_____

_____

_____

_____

Today's Date: ____ /____ /____

Print Name: _____

Signature: _____