

Genetics of Strabismus Scorecard

Date (mm/dd/year): _____
Subject Name (Last, First): _____
Subject Date of Birth (mm/dd/year): _____

Check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Diagnosis of Strabismus | <input type="checkbox"/> Eye Exercises |
| <input type="checkbox"/> Diagnosis of Amblyopia | <input type="checkbox"/> Glasses During Childhood |
| <input type="checkbox"/> Eye Alignment Surgery | <input type="checkbox"/> Significant Refractive Error |
| <input type="checkbox"/> Patching of an Eye | <input type="checkbox"/> Problems with Depth Perception |

Instructions:

Please check any of the boxes above that pertain to your medical history. All of the items listed below are characteristic of Strabismus. This form will be used to help us better understand the characteristics of Strabismus that are inherent in you and your family. After completing this form, please send it to Jenn Baird at:

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