Supplement 1. Questionnaire form

Questions	Please check the appropriate box.
Who is answering this questionnaire?	□ Patient (self) □ Mother □ Father □ Grandparent □ Etc._____
What is the reason for this visit?	Answer:
Have you ever visited other clinics?	□ No □ Yes Name of the clinic:_____ Previous diagnosis:_____
Have you ever noticed the ocular misalignment?	□ Yes □ No □ Not sure
- Who noticed the symptom first? (Example: parents, teacher, doctor etc.)	Answer:
- When did you first notice the symptom?	Answer: years ago (years of age)
How often in a day do you notice the symptom?	□ None □ Less than once □ Once or more
What is the direction of the ocular misalignment?	□ Inward □ Outward □ Upward □ Not sure □ Etc.:_____
Which eye do you think is misaligned?	□ None □ Right □ Left □ Alternate □ Not sure □ Etc.:_____
Have you ever noticed having an abnormal head posture?	□ None □ Tilt □ Head turn □ Etc._____
How often do you notice the abnormal head posture?	□ Always □ Sometimes □ Etc._____
Please select all of the symptoms which the patient presents.	□ Frowning □ Discomfort at near sight □ Headache □ Ocular pain □ Visual blurring □ None □ Not sure □ Things look smaller than they really are
Any diplopia at near sight?	□ None □ Not sure □ Less than once in a day □ Once or more in a day
Any diplopia at far sight?	□ None □ Not sure □ Less than once in a day □ Once or more in a day
Has the patient ever received occlusion therapy?	□ Yes □ No
- Prescribed period and duration?	Period:_____~_____ Duration in a day:_____
- Which eye?	□ Right □ Left □ Alternate
- Real period and duration?	Period:_____~_____ Duration in a day:_____
Does the patient wear the glasses?	□ Never □ Yes Since when:_____
Did the patient ever undergo any type of surgery (including ocular surgery)?	□ None □ Yes Name of the surgery:_____
Has the patient ever been diagnosed with any medical conditions? (Systemic disease, Developmental delay, ADHD, Brain disease, etc.)	□ None □ Yes Diagnosis:_____
Questions about birth history.	□ Normal spontaneous vaginal delivery □ Caesarean section □ Not sure
- Gestational age (weeks), birth weight (kg), prematurity?	Answer:_____weeks _____kg □ prematurity
- Any problems at birth? (example: breathing difficulty, lung disease*, delivery complications*)	□ None □ Yes Diagnosis:_____
Does the patient's mother have any form of strabismus?	□ No □ Yes (Diagnosis:_____) □ Not sure
- Any strabismus surgery history?	□ No □ Yes □ Not sure
Does the patient's father have any form of strabismus?	□ No □ Yes (Diagnosis:_____) □ Not sure
- Any strabismus surgery history?	□ No □ Yes □ Not sure
Do the patient's siblings have any form of strabismus?	□ No □ Yes (Diagnosis:_____) □ Not sure
- Any strabismus surgery history?	□ No □ Yes □ Not sure