### 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?                                         | Answer:                                                               |
| (Example: parents, teacher, doctor etc.)                                  |                                                                       |
| - 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                                                |