Children's Vision Questionnaire

Please fill out the following questionnaire completely and as accurately as possible:

General Information

Were you referred to our office? Yes No

If yes, who can we thank for the referral? _____

Patient Name _____

Patient Date of Birth _____ Age _____ years, _____ months

Name of School _____

Address of School _____

Grade _____ Teacher _____

School Nurse _____

Does your child have a history of fear of doctors? Yes No

Is there anything specific we can do to help ease the fear? _____

Dominant hand? Right Left

Responsible Party Information

Parent(s)/Guardian(s) Name(s): _____

Home Address _____

City _____ Zip _____ Phone _____

Medical History

Pediatrician's Name _____ Last Visit _____

Reason for last visit _____

Current medications (including vitamins and supplements) _____

_____

Medical conditions _____

_____

Has your child ever suffered a traumatic brain injury or concussion? Yes No (if yes, please explain. Where did the injury take place? Can you describe the events of the injury? Was there loss of consciousness? How long? Was there any treatment indicated for the brain injury? Please describe this event in detail)

_____

_____

_____

Is there any history of the following conditions, (if yes, please list current treatment):

Asthma? Yes No _____

Chronic ear infections? Yes No _____

ADD/ADHD? Yes No _____
Amblyopia (lazy eye)? Yes No _____
Strabismus (crossed eyes)? Yes No _____
Dyslexia? Yes No _____
Learning Disability? Yes No _____
Autism? Yes No _____

Allergies _____
Is your child generally healthy? Yes No (If no, explain) _____

Has a neurological evaluation been performed? Yes No
By whom and results? _____

Has a psychological evaluation been performed? Yes No
By whom and results? _____

Has an occupational therapy evaluation been performed? Yes No
By whom and results? _____

Family Medical History (if yes, please name family member

Diabetes	_____	Learning Disability	_____
Strabismus (crossed eyes)	_____	Seizures	_____
Amblyopia (lazy eye)	_____	Other	_____
Dyslexia	_____	ADHD	_____

Nutritional Information of Child
Diet: Excellent Good Fair Poor
Does your child: Like Sweets Crave Sweets Dislike Sweets
Is your child active? Not active Moderately Extremely
Does your child have periods of very high energy? Yes No
Periods of Very Low energy? Yes No
(If yes, please explain) _____

Developmental History
Full term pregnancy? Yes No (if no, please explain) _____
APGAR scores _____
Did the mother have any health problems during pregnancy? Yes No (if yes, please explain) _____
Normal birth? Yes No (if no, please explain) _____
Did your child crawl? Yes No Age_____
Did your child creep on all fours? Yes No Age_____

At what age did your child walk? _____
Active or Quiet? _____
Speech (first words and age)? _____
Any history of or current speech delays or concerns? _____

Visual History
Date of last eye exam _____ Doctor's Name _____
Reason for examination _____
Is your child prescribed glasses or contact lenses? Yes No
Do they wear their correction? Yes No
If yes, how frequently? _____
If no, why not? _____

Have any family members ever undergone vision therapy?
Name Age Reason
_____
_____
_____

Is there any evidence from the school or other practitioners or other tests that indicate some visual malfunction may be present? Yes No (if yes, explain) _____

Has your child reported any of the following symptoms? If yes, please explain further

Headaches	Yes No	_____
Blurred vision/focus goes in and out	Yes No	_____
Double Vision	Yes No	_____
Eyes hurt	Yes No	_____
Words move on the page	Yes No	_____
Motion sickness/car sickness	Yes No	_____
Dizziness	Yes No	_____

Have you or anyone else (other family members, teachers, other doctors etc) ever noticed the following? (If yes, please explain further)

Eyes frequently red	Yes No	_____
Frequent eye rubbing	Yes No	_____
Frequent styes	Yes No	_____
Frowning frequently	Yes No	_____
Bothered by light	Yes No	_____
Frequent blinking	Yes No	_____

Closing or covering one eye	Yes	No _____
Difficulty seeing distant objects	Yes	No _____
Holding paper close to face when reading	Yes	No _____
Prefers being read to (avoids reading)	Yes	No _____
Tilts head when reading	Yes	No _____
Tilts head when writing	Yes	No _____
Moves head when reading	Yes	No _____
Confuses letters or words	Yes	No _____
Reverses letters or words	Yes	No _____
Confuses right and left	Yes	No _____
Skips, rereads or omit words when reading	Yes	No _____
Loses place when reading	Yes	No _____
Vocalizes when reading silently	Yes	No _____
Reads slowly	Yes	No _____
Uses finger to read	Yes	No _____
Poor reading comprehension	Yes	No _____
Reading comprehension decreases over time	Yes	No _____
Writes or prints poorly	Yes	No _____
Writes neatly but slowly	Yes	No _____
Awkward pencil grip	Yes	No _____
Frequent erasing	Yes	No _____
Tires easily	Yes	No _____
Difficulty copying from board	Yes	No _____
Difficulty with memory	Yes	No _____
Remembers better if heard than read	Yes	No _____
Responds better orally than writing	Yes	No _____
Seems to know material, scores poorly on tests	Yes	No _____
Dislikes/avoids near tasks	Yes	No _____
Short attention span/loses interest	Yes	No _____
Poor large motor coordination	Yes	No _____
Poor fine motor coordination	Yes	No _____
Difficulty with scissors	Yes	No _____
Dislikes/avoids sports	Yes	No _____
Difficulty catching/hitting a ball	Yes	No _____

Television/Leisure Activities

Does your child watch TV? Yes No

How much? _____

Viewing distance _____

Does your child spend time using computer/video games? Yes No
How much? _____
Viewing distance _____

What other activities occupy your child's time? _____
Are there any activities your child would like to participate in, but doesn't? Yes No
Explain _____
Does your child play sports? Yes No
What sports? _____
Does your child excel or underperform in each sport?
_____

School
Age at the start of pre-school _____ Kindergarten _____
Does your child generally like school? Yes No (if no, explain) _____
Describe any specific school difficulties _____
Has any grade been repeated? Yes No (if yes, why)
_____
Has your child had any special tutoring, therapy or remedial assistance? Yes No
If yes, when? _____
With whom? _____
How long? _____
What subject was worked on? _____
Results ? _____
Does your child like to read? Yes No
Does your child read for pleasure? Yes No
Overall, schoolwork is: Above average Average Below Average
Which subjects are:
Above average _____
Average _____
Below average _____
Are there any specific testing areas on standardized testing that your child struggles in?
Yes No (if yes, which subjects)? _____
How much time does your child spend on homework daily? _____
How much help are you providing? _____
Do you feel your child is achieving his/her full potential in school? Yes No
Does your child struggle socially? Yes No (if yes, please explain)
_____

Is there any other information you feel would be helpful in our treatment of your child?

_____
_____
_____
_____