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CHILDREN'S VISION QUESTIONNAIRE

Please fill out this questionnaire carefully. Please return it to our office prior to your appointment.
THANK YOU.

Patient's Full Name:_____

General Information

Were you referred to our office? Yes □ No □

If yes, whom may we thank for this referral? _____

Birth Date: _____ Age:_____ Male □ Female □

Education Information

Grade: _____ Teacher: _____

Name of School:_____ City: _____

Child's Dominant Hand: Right □ Left □ Has guidance been given in use of hand? Yes □ No □

Family Information

Father's Name:_____ Occupation: _____

Mother's Name: _____ Occupation: _____

Siblings Names and Ages:

_____

_____

_____

Responsible Person Information (only fill out if patient is new to our practice)

Name: _____ Relation to patient: _____

Home Address: _____ City: _____ Zip: _____

Home/Cell Phone: _____Work Phone: _____

Driver's License #: _____

Medical History

Pediatrician's Name: _____ Date of last evaluation: _____

Have you been diagnosed with or are you being treated for any of the following? (**please circle or describe anything that is checked "yes"**)

☐ **Yes** ☐ **No**	General	(Severe fever, Significant weight loss/gain, Severe fatigue)
☐ **Yes** ☐ **No**	Ears, Nose, Throat	(Hearing loss, Sinus infection, Dry mouth)
☐ **Yes** ☐ **No**	Cardiovascular	(Heart disease, High blood pressure)
☐ **Yes** ☐ **No**	Respiratory	(Asthma, Bronchitis, Tuberculosis)
☐ **Yes** ☐ **No**	Kidney/Bladder	(Stones, Infection)
☐ **Yes** ☐ **No**	Muscles/Joints	(Arthritis, Gout)
☐ **Yes** ☐ **No**	Skin	(Eczema, Rosacea, Acne, Skin cancer)
☐ **Yes** ☐ **No**	Neurological	(Multiple sclerosis, Tremor, Memory loss)
☐ **Yes** ☐ **No**	Psychiatric	(Depression, Anxiety)
☐ **Yes** ☐ **No**	Endocrine	(Diabetes, Thyroid)
☐ **Yes** ☐ **No**	Blood	(High cholesterol, Anemia)
☐ **Yes** ☐ **No**	Allergic/Immunologic	(Seasonal allergies, Lupus)
☐ **Yes** ☐ **No**	Infectious Disease	(HIV, Hepatitis C)
☐ **Yes** ☐ **No**	Other	(Cancer)

***If you answered "Yes" to the above, please describe*:**

_____

_____

Current medications, including vitamins and supplements (including the conditions for which medications are used):

_____

_____

Reactions to immunization(s)? Yes □ No □ If yes, please explain_____

History of illnesses, bad falls, high fevers, etc.:

Age Severe/Mild Complications

_____

_____

Is your child generally healthy? Yes □ No □ If no, please explain: _____

_____

Are there any chronic problems like ear infections, asthma, hay fever, allergies, etc.? Yes □ No □

If yes, please list: _____

_____

Has your child had a neurological evaluation? Yes □ No □ If yes, by whom? _____

Results and recommendations: _____

_____

Has your child been tested for and/or diagnosed with:

ADHD? Yes □ No □ Autism? Yes □ No □ Other? _____

Please explain: _____

_____

Family History (please check if there's a family history and list who)

□ Diabetes _____ □ High Blood Pressure _____

□ Cross/Wall Eye _____ □ Learning Disability _____

□ Glaucoma _____ □ Amblyopia (Lazy eye) _____

□ Chromosomal Imbalance _____ □ Multiple Sclerosis _____

□ Epilepsy or Seizures

If other, please explain: _____

_____

Nutritional Information

Current diet: Excellent □ Good □ Fair □ Poor □ _____

Likes sweets □ Craves sweets □

If so, what types: _____

Is your child active? Yes □ No □

If so: Moderately □ Extremely □

Are there periods of: Very high energy? Yes □ No □ Very low energy? Yes □ No □

If so, please explain: _____

Developmental History

Full-term pregnancy? Yes □ No □ Adopted: Yes □ No □

Did the mother experience any health problems during pregnancy? Yes □ No □

If yes, explain: _____

Normal birth? Yes □ No □ _____

Any complications before, during, or immediately following delivery? Yes □ No □

If yes, explain: _____

Birth weight: _____ Were forceps used? Yes □ No □

Was there ever any reason for concern over your child's general growth or development?

Yes □ No □ If yes, why? _____

Did your child crawl (on belly and arms) Yes □ No □ creep (on all fours) Yes □ No □

At what age? _____ If not, please describe what child did instead: _____

At what age did your child walk? _____

Was child active? Yes □ No □ At what age did you child start talking? _____

Was speech clear to others? Yes □ No □ Is speech clear now? Yes □ No □

Is your child currently in **Speech Therapy** or have a history of speech therapy? Yes □ No □

Please explain:_____

Has your child had an **Occupational Therapy** evaluation or is currently in therapy? Yes □ No □

If yes, by whom? _____

Results and recommendations: _____

_____

Has your child taken part in any other type of therapy? Yes □ No □

If yes, by whom and for what condition? _____

Results and recommendations: _____

Visual History (only fill out if new patient to our practice)

Has your child's vision been previously evaluated? Yes □ No □ Date of exam:_____

Doctor's name/Office name: _____

Reason for exam: _____

Results and recommendations: _____

Were glasses, contact lenses or other optical devices recommended? Yes □ No □

Please explain: _____

Are they used? Yes □ No □ If yes, when? _____

If no, why not? _____

Members of the family who have had visual attention/visual difficulties and the reason: (list name, age, issue)

_____

_____

Present Situation

Why do you feel your child needs a visual evaluation? _____

_____

How long has this problem/difficulty been observed? _____

Is there any evidence from the school, psychological, or other tests that indicates some visual malfunction may be present? Yes □ No □ If yes, what? _____

_____

Does your child report any of the following?

- ☐ Headaches
- ☐ Eyes tired
- ☐ Blurred vision
- ☐ Words move on page
- ☐ Double vision
- ☐ Motion/car sickness
- ☐ Eyes hurt
- ☐ Dizziness

List any other complaints your child has concerning his/her vision:

_____

_____

Have you or others noticed the following:

- ☐ Eyes frequently reddened
- ☐ Frequent eye rubbing
- ☐ Frowning
- ☐ Bothered by light
- ☐ Frequent blinking
- ☐ Closing or covering one eye
- ☐ Difficulty seeing distant objects
- ☐ Head close to paper when reading or writing

Does your child:

- ☐ Avoid reading
- ☐ Prefers being read to
- ☐ Tilts head when reading
- ☐ Tilts head when writing
- ☐ Moves head when reading
- ☐ Confuses letter(s) or words
- ☐ Reverses letter(s) or words
- ☐ Confuses right and left
- ☐ Skips, rereads or omits words
- ☐ Loses place while reading
- ☐ Vocalizes when reading silently
- ☐ Reads slowly
- ☐ Uses finger as a place marker
- ☐ Poor reading comprehension
- ☐ Comprehension better when read to
- ☐ Comprehension decreases over time

- ☐ Writes or prints poorly
- ☐ Writes neatly but slowly
- ☐ Does not support paper when writing
- ☐ Awkward or immature pencil grip
- ☐ Frequent erasures
- ☐ Tires easily
- ☐ Difficulty copying from chalkboard

- ☐ Difficulty recognizing same word on different page
- ☐ Difficulty with memory
- ☐ Remembers better what is heard than seen
- ☐ Responds better orally than by writing
- ☐ Seems to know material, but tests poorly

- ☐ Dislikes/avoids near tasks
- ☐ Short attention span/loses interest

- ☐ Poor large motor coordination
- ☐ Poor fine motor coordination
- ☐ Difficulty with scissors
- ☐ Dislikes/avoids sports
- ☐ Difficulty catching/hitting a ball
- ☐ Other:_____

Leisure activities

Does your child watch TV? _____ How much/often? _____ Viewing distance? _____

Does your child use the computer/play video games? _____

If yes, how much/often? _____ Viewing distance? _____

Are there any activities your child would like to participate in, but doesn't? _____

If yes, please explain: _____

School

Age at time of entrance to: Preschool _____ Kindergarten _____ First Grade _____

Has your child repeated a grade: Yes □ No □ If yes, what grade and why?

_____

_____

Does your child like school? Yes □ No □

Specifically describe any school difficulties: _____

_____

Has your child changed schools often? Yes □ No □ If yes, when? _____

Does your child seem to be under tension or extreme pressure when doing school work? _____

_____

Has your child had any special tutoring, therapy, and/or remedial assistance? Yes □ No □

If yes, when? _____ Where and from whom? _____

How long? _____ Results: _____

Has your child been tested for and/or diagnosed with a **Learning Disability or Dyslexia**? Yes □ No □

If yes, by whom? _____

Results and recommendations: _____

_____

Does your child currently receive a **504** and/or an **IEP?** Yes □ No □ If yes, please explain:_____

_____

_____

Does your child like to read? Yes □ No □

Voluntarily? Yes □ No □

Does your child read for pleasure? Yes □ No □ If yes, what? _____

What is your child's attitude toward reading, school, his/her teachers, and other children?

_____

Overall, schoolwork is: above average □ average □ below average □

Which subjects are:

Above average? _____

Average? _____

Below average? _____

Does your child need to spend a lot of time/effort to maintain this level of performance? Y □ N □

How much time, on average, does your child spend per day on homework? _____

To what extent do you assist with homework? _____

Do you feel your child is achieving up to potential? Yes □ No □

Additional Comments:

_____

_____

_____

General Behavior

Are there any behavior problems at school? Yes □ No □ If yes, what? _____

Are there any behavior problems at home? Yes □ No □ If yes, what? _____

What causes these problems? _____

Child's reaction to fatigue: sag in posture □ irritable □ other □ _____

Child's reaction to tension: avoidance □ irritable □ other □ _____

Does your child say and/or do things impulsively? Yes □ No □

Is your child in constant motion? Yes □ No □

Can your child sit still for long periods? Yes □ No □

What motivates your child?_____

Family and Home

Please indicate which adult(s) child lives with:

□ Mother □ Father □ Stepmother □ Stepfather □ Foster Parents □ Grandmother □ Grandfather □ Aunt □ Uncle

Does your child spend time with any other person, not in the home? Yes □ No □

Please explain: _____

Has your child ever been through a traumatic family situation such as divorce, parental loss, separation, severe parental illness, etc? Yes □ No □ If yes, at what age? _____

Does your child seem to have adjusted? Yes □ No □

Was counseling/therapy undertaken? Yes □ No □ If yes, is it on-going? Yes □ No □

_____

_____

Is family life stable at this time? Yes □ No □ If no, please explain: _____

_____

How does your child get along with:

Parents/other caretakers? _____

Siblings? _____

Classmates? _____

Playmates at home? _____

Did father or mother or anyone in either family have a learning problem? Yes □ No □

If yes, who? _____

Do any, or did any, of the other children in the family have learning problems? Yes □ No □

If yes, who? Please Explain: _____

_____

Give a brief description of your child as a person:

_____

_____

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

_____