

CHILDRENS VISION QUESTIONNAIRE - EXTENDED

Please fill out this questionnaire carefully.

THANK YOU.

Patient's Name: _____

GENERAL INFORMATION

Were you referred to our office? Yes No

If yes whom may we thank for this referral? _____ Email: _____

Address: _____

Child's Full Name: _____ Male _____ Female _____

Birth Date: _____ Age: _____ years _____ months

Name and address of school: _____

Grade: _____ Teacher: _____ School Nurse: _____ Principal: _____

Is your child especially afraid of doctors? _____

Child's dominant hand (circle): right or left? Has guidance been given in use of hand? Yes No

Please list the names and birth dates of your family:

NAME

Father/Caretaker _____ Birth Date _____

Mother/Caretaker _____ Birth Date _____

Sibling _____ Birth Date _____

Sibling _____ Birth Date _____

Sibling _____ Birth Date _____

Sibling _____ Birth Date _____

RESPONSIBLE PERSON INFORMATION

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Father/Caretaker's Occupation: _____ Business Phone: _____

Business Address: _____ City: _____ Zip: _____

Mother/Caretaker's Occupation: _____ Business Phone: _____

Business Address: _____ City: _____ Zip: _____

Do you have Major Medical Insurance? Yes No

If so, who is the carrier? _____ Policy #: _____

Name of Insured: _____

Social Security Number: _____ Driver's License #: _____

MEDICAL HISTORY

Pediatrician's Name: _____ Date of Last Evaluation: _____

For what reason? _____

Results and recommendations: _____

Child's current state of health: _____

Medications currently using, including vitamins and supplements: _____

For what condition(s)? _____

Any reactions to immunization(s)? Yes No If yes, explain: _____

List illnesses, bad falls, high fevers, etc.:

<u>Age</u>	<u>Severe</u>	<u>Mild</u>	<u>Complications</u>
_____	_____	_____	_____
_____	_____	_____	_____

Is your child generally healthy? Yes No

If no, explain: _____

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

If yes, please list: _____

Has a neurological evaluation been performed? Yes No

By whom? _____ Results and recommendations: _____

Has a psychological evaluation been performed? Yes No

By whom? _____ Results and recommendations: _____

Has an occupational therapy evaluation been performed? Yes No

By whom? _____ Results and recommendations: _____

Is there any history of the following? (please check if there is a history)

	<u>Patient</u>	<u>Family</u>	<u>Who</u>		<u>Patient</u>	<u>Family</u>	<u>Who</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
“Cross” or “Wall” eye	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chromosomal				Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	_____	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

If other, please explain: _____

NUTRITIONAL INFORMATION

Current Diet: Excellent Good Fair Poor

Does your child: Like sweets or crave sweets

If yes, what types? _____

Is your child active? Yes No

moderately? Yes No

extremely? Yes No

Are there periods of

very high energy? Yes No

very low energy? Yes No

Explain: _____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes No

Did the mother experience any health problems during the 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: _____ Apgar scores @ birth: _____ After 10 minutes: _____

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 (stomach on floor)? Yes No At what age? _____

Did your child creep (on all fours)? Yes No At what age? _____

If not, describe: _____

At what age did your child walk? _____

Was child active? Yes No

Speech: First words: _____ At what age: _____

Was early speech clear to others? Yes No

Is speech clear now? Yes No

VISUAL HISTORY

Has your child's vision been previously evaluated? Yes No

If so, Doctor's Name: _____ Date of last evaluation: _____

Reason for examination: _____

Results and recommendations: _____

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

If yes, what? _____

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

If not used, why not? _____

Members of the family who have had visual attention and the reason:

<u>Name</u>	<u>Age</u>	<u>Visual Situation</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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:	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____

Blurred vision / focus goes in and out	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes hurt	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes tired	<input type="checkbox"/>	<input type="checkbox"/>	_____
Words move around on the page	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motion sickness / car sickness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____
List any other complaints your child makes concerning his/her vision:	_____		

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING:

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Eyes frequently reddened	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent eye rubbing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent sties	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frowning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bothered by light	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent blinking	<input type="checkbox"/>	<input type="checkbox"/>	_____
Closing or covering one eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty seeing distant objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head close to paper when reading or writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Avoids reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prefers being read to	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tilts head when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tilts head when writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Moves head when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Confuses letter or words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reverses letter or words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Confuses right and left	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skips, rereads or omits words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loses place while reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vocalizes when reading silently	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reads slowly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Uses finger as a marker	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor reading comprehension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Comprehension decreases over time	<input type="checkbox"/>	<input type="checkbox"/>	_____
Writes or prints poorly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Writes neatly but slowly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does not support paper when writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Awkward or immature pencil grip	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent erasures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tires easily	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty copying from chalkboard	<input type="checkbox"/>	<input type="checkbox"/>	_____

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Difficulty recognizing same word on different page	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor word attack skills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with memory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Remembers better what hears than sees	<input type="checkbox"/>	<input type="checkbox"/>	_____
Responds better orally than by writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seems to know material, but does poorly on tests	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dislikes / avoids near tasks	<input type="checkbox"/>	<input type="checkbox"/>	_____
Short attention span / loses interest	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor large motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor fine motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with scissors / small hand tools	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dislikes / avoids sports	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty catching / hitting a ball	<input type="checkbox"/>	<input type="checkbox"/>	_____

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Does child watch TV? _____ How much? _____ How often? _____ Viewing distance? _____
 Does your child spend time using computer/video games? Yes No
 If yes, how much? _____ How often? _____ Viewing distance? _____
 What other activities occupy your child's leisure time? _____
 Are there any activities your child would like to participate in, but doesn't? _____
 Please explain: _____

SCHOOL

Age at time of entrance to: Pre-school _____ Kindergarten _____ First Grade _____
 Does your child like school? Yes No
 Specifically describe any school difficulties: _____

 Has your child changed schools often? Yes No
 If yes, when? _____
 Has a grade been repeated? Yes No
 If yes, which and why? _____
 Does your child seem to be under tension or extreme pressure when doing school work? Yes No
 Has your child had any special tutoring, therapy, and/or remedial assistance? Yes No
 If yes, when? _____
 Where and from whom? _____
 How long? _____
 Results: _____
 Does your child like to read? Yes No
 Voluntarily? Yes No
 Does your child read for pleasure? Yes No
 What? _____

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

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?

Yes No

How much time on average does your child spend each day on homework assignments? _____

To what extent do you assist your child with homework? _____

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

Does the teacher feel your child is achieving up to potential? Yes No

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 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

FAMILY AND HOME

Please indicate which adult(s) he/she lives with? Mother Father Stepmother

Stepfather Foster Parents Adoptive Parents Grandmother Grandfather

Aunt Uncle Other Caretaker (please specify): _____

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)? 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 in school? _____

Playmates at home? _____

Did father or anyone in father's family have a learning problem? Yes No

If yes, who? _____

Did mother or anyone in mother's 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? _____

To what extent? _____

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?

RELEASE OF INFORMATION AND INSURANCE FILING

IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH YOUR CHILD’S SCHOOL AND/OR OTHER PROFESSIONALS INVOLVED IN HIS/HER CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I agree to permit information from, or copies of, my child’s examination records to be forwarded to my child’s school, other health care providers or insurance carriers upon their written request or upon the recommendation of Visualeyex Optometry when it is necessary for the treatment of my child’s visual condition, or for the processing of insurance claims. I authorize Visualeyex Optometry to exchange information with my child’s school and other professionals involved in my child’s care, by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

Signature

Date

RELATIONSHIP TO PATIENT

I hereby give my permission to Visualeyex Optometry to treat _____
(Child’s Name)

Parent’s or Guardian’s Signature

Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us perform a more comprehensive evaluation of your child and to better meet your child’s specific visual needs.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us.

You may leave a message for us 24 hours a day /7 days a week. We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your child’s visual status.

THANK YOU.

SINCERELY,

Susan Kim, O.D.
CLINICAL DIRECTOR