CHILDREN'S VISION QUESTIONNAIRE

Please fill out this questionnaire carefully.

Please bring the completed form with you on the day of the evaluation. Thank you!

GENERAL INFORMATION: Today's Date: _____

Patient's Full Name:_____ Age_____ Birth Date_____

Mother's Name:_____ Father's Name:_____

Were you referred to our office? Yes_____ No_____

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

Phone:_____ Fax:_____

VISUAL HISTORY:

What is the main reason for today's vision exam?_____

_____

How long has this problem/difficulty been observed?_____

Has there been a recent vision exam? Yes_____ No_____

If yes, Date:_____ Name of Doctor: _____

Results and recommendations:_____

Are glasses or contacts worn? (please circle all that apply) If so, how often?_____

*Contact Prescription: (or please bring a copy of your prescription from your optometrist, **this will be needed for exam**)

R – brand_____ base curve _____ diameter _____ sphere_____

L – brand_____ base curve _____ diameter _____ sphere_____

*Glasses Prescription: (or please bring a copy of your prescription from your optometrist, **this will be needed for exam**)

R – Sphere _____ Cylinder _____ Axis_____ Add_____ Prism? Vert/Hori _____

L – Sphere _____ Cylinder _____ Axis_____ Add_____ Prism? Vert/Hori _____

Have the following vision problems been diagnosed?

Amblyopia (lazy eye)_____ If so, when were you diagnosed?_____ Treatment? _____

Strabismus (eye turn)_____ If so, when were you diagnosed?_____ Treatment? _____

VISUAL SYMPTOM SURVEY – Please complete all, and ask the child when appropriate

Please rank each of the following symptoms. 0= Never, 1= Seldom, 2= Occasionally, 3= Frequently, 4= Always

Symptoms	0	1	2	3	4
Blur when looking at near					
Double Vision					
Headaches with near work					
Words run together when reading					
Burning, stinging, watery eyes when reading					
Falls asleep when reading					
Vision worse at the end of the day					
Skips/repeats lines when reading					
Dizzy/Nauseous with near work					
Tilts head or closes one eye when reading					
Difficulty copying from far to near					
Reversal of letters like b's, d's, p's and q's					
Avoids near work/reading					
Omits small words when reading					
Writes up/down hill					
Misaligns digits/columns of numbers					
Reading comprehension declines over time					
Poor/inconsistent in sports					
Holds reading material too close					
Short attention span					
Difficulty completing assignments on time					
Says "I can't" before trying					
Avoids sports/games					
Poor eye-hand coordination					
Does not judge distance accurately					
Clumsy, knocks things over					
Loses belongings/things					
Car/motion sickness					
Forgetful/poor memory					
Sensitive to lighting (too light/too dark)					
Poor Handwriting					
Totals (office use only)					

List any other vision related concerns: _____

_____

_____

ACADEMIC INFORMATION:

School:_____ Current Grade:_____ Teacher:_____

Has a grade been repeated? If so which grade? Yes____ No_____ Grade repeated:_____

Does your child generally like school? Yes____ No_____

Is assistance required to complete homework? Yes_____ No_____

Specifically describe any school difficulties:_____

_____

Any special tutoring and/or remedial assistance? Yes____ No____

If yes, describe the type and frequency of assistance:_____

_____

Does your child like reading? Yes_____ No_____ Does your child read for pleasure? Yes____ No____

How does your child perform in the following subject areas:

Reading:_____ Social Studies/History:_____

Writing:_____ Art:_____

Science:_____ Other:_____

Math:_____

Favorite Subject:_____ Least Favorite Subject:_____

Overall academic performance is:_____

Is a great deal of effort spent to maintain this level of performance?_____

Do you feel achievement is up to potential? Yes_____ No_____

Does/Do the teacher(s) feel achievement is up to potential Yes_____ No_____

Other comments about Academic Performance:_____

_____

MEDICAL HISTORY:

Primary Care Doctors Name: _____

Address:_____

_____

Phone: _____ Fax:_____

Would you like a report sent to this doctor? Yes_____ No_____

Medications: (including any vitamins, supplements and reason for taking)

_____

_____

_____

_____

Any medication allergies? Yes_____ No_____

If yes, name of medication:_____ Reaction: _____

List any significant illnesses, head injury, surgical procedures, etc.:

Age Severity Complications

_____

_____

Any chronic health problems like asthma, hay fever, allergies, etc.? Yes_____ No_____
If yes, please explain,_____
Do your child have problems now or previously in the following areas:

Condition	**Circle one**	**If so, please explain**
Cancer	Y or N	
Weight loss/gain	Y or N	
Skin	Y or N	
Allergies	Y or N	
Neurological	Y or N	
Ear/Nose/Throat	Y or N	
Psychological	Y or N	
Endocrine/Hormone	Y or N	
Diabetes	Y or N	When were they diagnosed?
Heart or Vascular	Y or N	
Blood	Y or N	
Gastrointestinal	Y or N	
Kidney	Y or N	
Bladder	Y or N	
Muscle Pain	Y or N	
Joint Pain	Y or N	
Autoimmune disease	Y or N	
Infectious disease (HIV, Hepatitis, etc)	Y or N	
Other	Y or N	

FAMILY HISTORY:
Has anyone in your immediate family had or currently have any problems in the following areas:

Condition	**Circle one**	**Who?**	**Condition**	**Circle one**	**Who?**
Diabetes	Y or N		Blindness	Y or N	
Heart Disease	Y or N		Macular Degeneration	Y or N	
High Blood Pressure	Y or N		Strabismus (eye turn)	Y or N	
Kidney Disease	Y or N		Amblyopia (lazy eye)	Y or N	
Thyroid Disease	Y or N		Glaucoma	Y or N	
Cancer	Y or N		Retinal Detachment	Y or N	
Rheumatoid Arthritis	Y or N		Learning Disability	Y or N	
Other	Y or N				

SPECIAL TESTING:

Has a neurological evaluation been performed? Yes_____ No_____ If so, by whom? _____
Results and Recommendations:_____
_____
Has a psychological evaluation been performed? Yes____ No____ If so, by whom? _____
Results and Recommendations:_____
_____
Has an occupational therapy evaluation been performed? Yes____ No____ If so, by whom?_____
Results and Recommendations:_____
_____
Has a physical therapy evaluation been performed? Yes____ No____ If so, by whom?_____
Results and Recommendations:_____
_____
Has a speech/hearing evaluation been performed? Yes____ No____ If so, by whom?_____
Results and Recommendations:_____
_____
Has educational testing been performed? Yes____ No____ If so, by whom? _____
Results and Recommendations:_____
_____

NUTRITIONAL INFORMATION:

Are there any food allergies/sensitivities? Yes_____ No_____ If yes, describe:_____
_____
Is a special diet in place? Yes_____ No_____ Previous dietary treatments/restrictions:_____
_____

BIRTH AND DELIVERY INFORMATION:

Describe any complications during pregnancy (injury, fever, illness, smoking, use of alcohol, prescription drug use, malnutrition, etc.)
_____
_____
Length of pregnancy (weeks):_____ Type of delivery?_____ Birth Weight:_____
Describe any complications during birth (vacuum, forceps, Pitocin, oxygen deprivation, use of oxygen)_____
_____

DEVELOPMENTAL HISTORY:

Were there ever any concerns regarding growth or development? Yes_____ No_____
At what age did your child reach the following milestones:
Crawl (on all fours)?_____ Walk (without support)?_____
Sit up (without support)?_____ First words?_____
Describe any speech concerns:_____
Did your child have difficulty learning to ride a tricycle or bicycle? Yes_____ No_____
Did your child have difficulty learning to run or skip? Yes_____ No_____
Did your child have difficulty learning to tie shoes or button clothes? Yes_____ No_____

Is your child generally well-coordinated or clumsy?_____

LEISURE TIME ACTIVITIES:

Does your child play computer/video games? If so, how many hours a day? _____
How many hours does your child spend outside each day? _____
Which sports does your child play?_____
What other activities/hobbies does your child enjoy?_____
_____
Are there any activities your child would like to participate in, but doesn't?_____
_____

GENERAL BEHAVIOR:

Are there any behavior problems at home?_____
Are there any behavior problems at school?_____
What is your child's reaction to fatigue?_____
Does your child say and/or do things impulsively?_____
Does your child have difficulty sitting for tasks? Please describe:_____
Does your child SEEK vestibular or sensory inputs? Please describe:_____
Does your child AVOID vestibular or sensory inputs? Please describe:_____

FAMILY AND HOME LIFE:

Please indicate which adult(s) your child lives with: (check all that apply)

___ Mother ____Stepmother ____Grandmother ____Aunt _____Foster Parents
___Father ____Stepfather ____Grandfather ____Uncle _____Adoptive Parents

Other (please specify):_____
Has your child ever been through a traumatic family situation (such as a divorce, parental loss, separation, severe parental illness)? Yes_____ No_____
What was the situation? _____ How old was your child?_____
Is family life stable at this time? Yes____ No____ If so, please explain:_____
Did any immediate family members have learning problems? If so, please explain:_____
_____

Give a brief description of your child as a person:_____
_____
_____
Is there any other information that you feel would be helpful/important for the doctor to know?_____
_____
_____