

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? If so, how often? _____

Have the following vision problems been diagnosed?

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

List any treatment or therapy for this condition (past or present) _____

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

List any treatment or therapy for this condition (past or present) _____

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)					
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 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? _____