Utah Vision Solutions James David O.D., FCOVD
459 N 300 W #10 Kaysville, UT 84037 (801) 546-3355 utahvisionsolutions@gmail.com

CHILDRENS VISION QUESTIONNAIRE - EXTENDED

Please fill out this questionnaire carefully and bring it with you to your first appointment.

THANK YOU.

Appointment: Day _____ Date _____ Time _____
Patient's Name: _____

GENERAL INFORMATION

Were you referred to our office ? Yes ☐ No ☐
If yes whom may we thank for this referral? _____ Phone: _____
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 names and ages of your family (this is optional, but helpful to get a basic idea of the child's family)
Father/Caretaker _____ Age _____
Mother/Caretaker _____ Age _____
Sibling _____ Age _____
Sibling _____ Age _____
Sibling _____ Age _____
Sibling _____ Age _____

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 ☐
(We don't contract w/ Insurance but may be able to provide specific helpful information if we know your carrier)
If so, who is the carrier? _____ _____

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)? _____
_____

Immunizations current? _____

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

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

Age	Severe	Mild	Complications

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: _____
Any recent changes in: clumsiness, nausea, speech patterns, handwriting, or mood? Yes ☐ No ☐

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)

	Patient	Family	Who		Patient	Family	Who
Diabetes	☐	☐	_____	High Blood Pressure	☐	☐	_____
"Cross" or "Wall" eye	☐	☐	_____	Learning Disability	☐	☐	_____
Chromosomal Imbalance	☐	☐	_____	Amblyopia (lazy eye)	☐	☐	_____
Glaucoma	☐	☐	_____	Multiple Sclerosis	☐	☐	_____
				Epilepsy or Seizures	☐	☐	_____
				Other	☐	☐	_____

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:

Name	Age	Visual Situation
_____	____	_____
_____	____	_____
_____	____	_____

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?:	Yes	No	If yes, when?
Headaches	☐	☐	_____
Blurred vision / focus goes in and out	☐	☐	_____
Double vision	☐	☐	_____

Eyes hurt	☐	☐	_____
Eyes tired	☐	☐	_____
Words move around on the page	☐	☐	_____
Motion sickness / car sickness	☐	☐	_____
Dizziness	☐	☐	_____

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

Appearance of Eyes

☐ Reddened eyes or lids
☐ Excessive tearing of eyes, or rubs eyes
☐ Blinks excessively

Refractive Error or Eye Focusing (Accommodation) Problem

☐ **Blinks eyes excessively during near tasks**
☐ **Frowns, scowls, or squints to see blackboard**
☐ **Avoids close work**
☐ **Fatigues easily during visual tasks**
☐ **Rubs eyes during or after visual activity**
☐ **Complains of blur while reading or writing**
☐ **Comprehension is poor when reading or performing near tasks**

Eye Tracking (Ocular Motility) Problem

☐ **Skips or rereads words or letters**
☐ **Rereads lines or phrases**
☐ **Mistakes words with similar beginnings or endings**
☐ **Uses finger or marker when reading**
☐ **Loses place often when reading**
☐ **Repeatedly omits "small" words**
☐ **Moves head excessively as reads across page**

Eye Teaming (Binocularity) Problem

☐ **Complains of seeing double**
☐ **Covers or closes one eye**
☐ **One eye turns (in, out, up, or down) at any time**
☐ **Tilts or turns head to one side**
☐ **Squints, closes, or covers one eye**
☐ **Complains of letters or lines "floating," "running together," or "jumping around"**
☐ **Reports confusion of what is seen**

Visual Information-Processing Problem

- ☐ **Confuses similar words**
- ☐ **Fails to recognize same word in next sentence or page**
- ☐ **Confuses minor likenesses and differences**
- ☐ **Makes errors in copying from chalkboard or reference book**
- ☐ **Difficulty following verbal instructions**
- ☐ **Difficulty completing assignments in time allotted**
- ☐ **Poor printing or handwriting**
- ☐ **Short attention span, distractible**
- ☐ **Says words aloud or moves lips as reads**
- ☐ **Reverses letters, numbers, or words**
- ☐ **Poor ability to remember what is read**
- ☐ **Poor eye-hand coordination**
- ☐ **Repeatedly confuses right-left directions**
- ☐ **Poor recall of visually-presented tasks**
- ☐ **School performance not up to potential**

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 upon their written request or upon the recommendation of Utah Vision Solutions when it is necessary for the treatment of my child's visual condition. I authorize Dr. David and Utah Vision Solutions 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 Utah Vision Solutions 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 on 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,

JAMES DAVID, O.D., FCOVD