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CHILDRENS VISION QUESTIONNAIRE

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

THANK YOU

Patient's Name:_____
Birth Date:_____Age:_____Male ☐ Female ☐

Name and City/State of School:_____
Grade:_____Teacher:_____
Is your child especially afraid of Doctors? Yes ☐ No ☐

GENERAL INFORMATION
Were you referred to our office ? Yes ☐ No ☐
If yes whom may we thank for this referral?_____Phone:_____
Office/Clinic of referral?_____

CHIEF COMPLAINT/ MAJOR CONCERN:
Briefly explain the concerns that prompted you to come to our office:
_____
_____
_____

RESPONSIBLE PERSON INFORMATION
Home Address: _____

Mother/Caretaker's Name: _____ Cell #: _____
Occupation:_____Work or Secondary #:_____
Email Address:_____

Father/Caretaker's Name: _____ Cell #: _____
Occupation:_____Work or Secondary #:_____
Email Address:_____

Do you have Major Medical Insurance? Yes ☐ No ☐
If so, who is the carrier?_____
Name of Insured:_____

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)? _____
_____

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

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

If any other siblings or family members have any sort of reading struggles or diagnoses of ADHD or dyslexia, or visual struggles of any kind, 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
extremely high energy? Yes ☐ No ☐
exceptionally 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 ☐
If no, explain: _____

Any reason for concern over your child's general growth or development? Yes ☐ No ☐
If yes, why? _____

_____

When did your child: Creep (stomach on floor)? Never ☐ Early ☐ Average ☐ Late ☐
Crawl (move on all fours)? Never ☐ Early ☐ Average ☐ Late ☐
At what age did your child walk? _____
Child's first words were: ☐ Early ☐ Average ☐ Late ☐
Was early speech clear to others? Yes ☐ No ☐
Is child's speech clear now? Yes ☐ No ☐
Was Speech Therapy Required? Yes ☐ No ☐
What Age(s)? _____

VISUAL HISTORY

Has your child's vision been previously evaluated by an eye doctor? 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 any eye or vision issues:

Name	Age	Visual Situation

PRESENT SITUATION

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 <u>any</u> 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? _____Viewing distance? _____
Does your child spend time using computer/video games? Yes ☐ No ☐
If yes, how much? _____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 extreme pressure when doing schoolwork? 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 ☐
<u>Which Subjects Are:</u>
Above average: _____
Average: _____
Below average: _____
Does he/she 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? _____
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? sad ☐ 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

How does your child get along with:

Parents/other caretakers? _____

Siblings? _____

Classmates in school? _____

Playmates at home? _____

Who does your child live with? _____

_____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON: _____

_____

_____

_____

_____

_____

_____

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 Utah Vision Solutions when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. 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

Symptom Survey

Name _____ DATE __/__/__

Patient instructions: Please answer the following questions about how your eyes feel when reading or doing close work. If patient is a child, please read instructions and then each item exactly as written.

		Never	Infrequently (not often)	Sometimes	Fairly often	Always
1.	Do your eyes feel tired when reading or doing close work?					
2.	Do your eyes feel uncomfortable when reading or doing close work?					
3.	Do you have headaches when reading or doing close work?					
4.	Do you feel sleepy when reading or doing close work?					
5.	Do you lose concentration when reading or doing close work?					
6.	Do you have trouble remembering what you have read?					
7.	Do you have double vision when reading or doing close work?					
8.	Do you see the words move, jump, swim or appear to float on the page when reading or doing close work?					
9.	Do you feel like you read slowly?					
10.	Do your eyes ever hurt when reading or doing close work?					
11.	Do your eyes ever feel sore when reading or doing close work?					
12.	Do you feel a "pulling" feeling around your eyes when reading or doing close work?					
13.	Do you notice the words blurring or coming in and out of focus when reading or doing close work?					
14.	Do you lose your place while reading or doing close work?					
15.	Do you have to re-read the same line of words when reading?					
		__x 0	__ x 1	__ x 2	__ x 3	__ x 4

TOTAL SCORE _____

Note: A score 16 or more indicates the need for a binocular vision evaluation. To schedule the evaluation please feel free to contact our office.