

CHILDRENS VISION QUESTIONNAIRE - EXTENDED

*Please fill out this questionnaire carefully. Please return it to our office prior to your appointment in the envelope provided. **THANK YOU.***

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: _____

Birth Date: _____ Age: _____ years _____ months
 Male _____ Female _____

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:

| <u>NAME</u> | Birth Date |
|------------------------|------------|
| Father/Caretaker _____ | _____ |
| Mother/Caretaker _____ | _____ |
| Sibling _____ | _____ |
| Sibling _____ | _____ |
| Sibling _____ | _____ |
| Sibling _____ | _____ |

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)? _____

Immunizations child has received:

Immunization type: _____ Date: _____
Immunization type: _____ Date: _____
Immunization type: _____ Date: _____
Immunization type: _____ Date: _____

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 discuss examination results and to exchange information with other co-managing professionals. Please sign below to authorize the release of information.

I agree to permit information from, or copies of, my examination records to be exchanged with other health care providers or provided to insurance carriers upon their written request or upon the recommendation of the VISION DEVELOPMENT CENTER, P.C., when it is necessary for treatment or for the processing of insurance claims. This authorization shall be valid for the duration of treatment.

Signature or Authorized Representative

Date

WAIVER OF DILATED FUNDUS EXAM

Services offered at the VISION DEVELOPMENT CENTER, P.C. do not include dilation and evaluation of ocular health. Dilation involves instilling drops in your eyes to enlarge the pupils. This allows your primary care optometrist to see better into the back of the eyes and evaluate the health of the eyes.

I understand that it is the recommendation of Vision Development Center, P.C. that a dilated fundus exam be performed prior to receiving the services offered therein. I also understand that refusing to have my eyes dilated may result in various ocular diseases to go undetected which may adversely affect my eyes and/or vision.

Signature or Authorized Representative

Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us. We request a minimum of 24 hours notice if you are unable to keep this appointment.

Thank you!



Joan Bauernfiend, O.D.
Vision Development Center, P.C.