

PRESCHOOL VISION QUESTIONNAIRE

***Please fill out this questionnaire carefully. Please return it to our office prior to your 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: _____

Birth Date: _____ Age: _____ years _____ months

Delivery Due Date: _____

Please list the names and birth dates of your family:

NAME

Father/Caretaker: _____

Birth Date: _____

Mother/Caretaker: _____

Birth Date: _____

Sibling: _____

Birth Date: _____

Sibling: _____

Birth Date: _____

Sibling: _____

Birth Date: _____

Sibling: _____

Birth Date: _____

RESPONSIBLE PERSON INFORMATION

Father/Caretaker Home Address: _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Place of Employment & Position _____ Work Phone _____

Email Address _____

Mother/Caretaker Home Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Place of Employment & Position _____ Work Phone _____

Email Address _____

Do you have Major Medical Insurance? Yes No

If so, who is the carrier? _____ Policy # _____

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)? _____

Immunizations child has received:

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

Any reactions to immunization(s)? Yes No _____

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

Has a neurological evaluation been performed? Yes No

By whom? _____ Results & recommendations _____

Has a psychological evaluation been performed? Yes No

By whom? _____ Results & recommendations _____

Has an occupational therapy evaluation been performed? Yes No

By whom? _____ Results & recommendations _____

Is there any history of the following: (please check if there is a history)

	<u>Patient</u>	<u>Family</u>	<u>Who</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
"cross" or "wall" eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chromosomal imbalance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple Sclerosis	<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 _____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes No _____

Did mother experience any problems during pregnancy? Yes No

If yes, please explain _____

Normal birth? Yes No

Were forceps used? Yes No

Any complications before, during or immediately following delivery? Yes No

Birth weight _____ Apgar scores @ birth _____ After 10 minutes _____

Were there any difficulties at all in feeding (such as difficulty with sucking, vomiting?) Yes No

If yes, please explain _____

Any problems with colic? Yes No

Was there ever any reason for concern over your child's general growth or development? Yes No

If yes, why? _____

Has your child received any special developmental guidance/assistance? Yes No

If yes, explain _____

How many hours daily does your child sleep? _____

Does your child sleep through the night? Yes No If yes, starting at what age: _____

If no, explain _____

What percent of the waking hours is/was your child in a playpen? _____

In a walker? _____

In a seat? _____

What things can your child do very well? _____

What things, if any, are difficult for your child? _____

NUTRITIONAL INFORMATION

Current Diet: Nursed Nursed until what age _____ Bottle fed

Solid food started at what age _____

Are there any food allergies/sensitivities? Yes No

If yes, what _____

Activity level: High Moderate Low

Are there periods of very high energy? Yes No

Are there periods of very low energy? Yes No

Does your child: Like sweets and/or Crave sweets

If so, what _____

What are his/her favorite foods? _____

What are his/her disliked/avoided foods? _____

VISUAL HISTORY

Why do you feel your child needs a visual examination? _____

Has your child's vision been previously evaluated? Yes No

If so, Doctor's Name _____ Date of last evaluation _____

Reason for evaluation _____

Results & 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? _____

Was surgery, therapy or other treatment recommended? Yes No

If yes, what? _____

Members of the family who have had visual attention and the reason:

<u>Name/Relationship</u>	<u>Age</u>	<u>Visual Situation</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check "yes" or "no" to the following observations and/or complaints as they relate to your child:

	Yes	No	If yes, when?
An eye turns in or out	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reddened or encrusted eyelids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent sties	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes in constant motion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyelids droop	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stares at bright lights or repeatedly flicks objects in front of face	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is abnormally bothered by bright light	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seems visually unaware	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Turns head to use one eye only	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tilts head to one side	<input type="checkbox"/>	<input type="checkbox"/>	_____
Moves objects very close to look at them	<input type="checkbox"/>	<input type="checkbox"/>	_____
Squints while looking at objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blinks excessively	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has a tendency to rub eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Covers or closes one eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stumbles over objects or is clumsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor motor control	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lacks interest in looking at objects or seeing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unable to see distant objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unable to transfer object from hand to hand, or crossing the midline of the body	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is unable to stack blocks or other objects	<input type="checkbox"/>	<input type="checkbox"/>	_____

Does your child verbalize any problems/complaints about his/her eyes or vision? Yes No

If yes, explain _____

PRE-SCHOOL

*****If your child attends pre-school, please fill out the following:

Name of Pre-school _____ Teacher _____ Director _____

Age at time of entrance to pre-school _____

Does your child like pre-school? Yes No

Does your child like the teacher? Yes No

Compared to other children his/her age, do his/her general performance and social skills seem to be
above equal to or below

Please explain _____

Which pre-school activities are easy for your child? _____

Which pre-school activities are difficult for your child? _____

Specifically describe any pre-school/day care concerns/difficulties _____

Does your child seem to be under tension at pre-school/day care? Yes No

If yes, explain _____

CURRENT ABILITIES/BEHAVIOR

Where appropriate, list the age at which your child could do the following: (some of these behaviors may not apply due to your child’s chronological age).

	<u>Age</u>		<u>Age</u>
Responsive smile	_____	Stack blocks	_____
Crawl (stomach on floor)	_____	Walk alone	_____
Roll over	_____	Scribble spontaneously	_____
Creep (stomach off floor)	_____	Kick a ball	_____
Sit up alone	_____	Walk up steps with help	_____
Respond to words & names	_____	Use two-word sentences	_____
Say single words	_____	Become toilet-trained	_____
Give first name	_____	Put on some clothing alone	_____

Can identify some colors? Yes No If yes, which? _____

Can your child identify numbers or letters? Yes No If yes, which? _____

Does your child like to draw/color? Yes No

Is your child learning to read? Yes No

How is your child performing as compared to others his/her age?

Above average Below average

How well developed is your child’s spoken vocabulary? _____

How well does your child understand / respond to spoken language? _____

Check the appropriate spaces if you have any concerns about the following behavior(s) in your child:

- | | | | |
|--------------------|--------------------------|--|--------------------------|
| Lack of curiosity | <input type="checkbox"/> | Irritable, easily upset | <input type="checkbox"/> |
| Thumb-sucking | <input type="checkbox"/> | Restlessness | <input type="checkbox"/> |
| Nervous | <input type="checkbox"/> | Has difficulty separating from parents | <input type="checkbox"/> |
| Glum, sulky, moody | <input type="checkbox"/> | Sleeplessness | <input type="checkbox"/> |
| Bad temper | <input type="checkbox"/> | Lethargic, low energy | <input type="checkbox"/> |
| Passive | <input type="checkbox"/> | Aggressive | <input type="checkbox"/> |

Other, (please explain) _____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON

Is there any other information that would be helpful/important in our evaluation or treatment of your child?

