

CHILDREN'S QUESTIONNAIRE

Please fill out this questionnaire carefully. 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
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>	
Father/Caretaker _____	Birth Date _____
Mother/Caretaker _____	Birth Date _____
Sibling _____	Birth Date _____
Sibling _____	Birth Date _____
Sibling _____	Birth Date _____
Sibling _____	Birth Date _____

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: _____

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: _____

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>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>	_____	Chromosomal Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	_____

Any history in your family of an eye turn resulting from a disease or other condition? Yes No

Other health problems? Yes No

If yes, please explain: _____

Was there any related trauma, disease, or condition that preceded or accompanied the onset of the eye turn?

Yes No

If yes, please explain: _____

Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes No

If yes, please list: _____

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

<u>Age</u>	<u>Severe</u>	<u>Mild</u>	<u>Complications</u>
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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: _____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes No

Did the mother experience any problems during pregnancy? Yes No

Normal birth? Yes No

Were forceps used? Yes No

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

Did your child crawl (stomach on floor)? Yes No At what age? _____

Did your child creep (stomach off floor)? Yes No At what age? _____

At what age did your child sit up (without support)? _____

At what age did your child walk (without support)? _____

First words: _____ At what age? _____

At what age did your child speak in a simple sentence (string two words together)? _____

Was your child alert as an infant? Yes No

Were there ever any concerns regarding growth or development? Yes No

If so, explain: _____

NUTRITIONAL INFORMATION

Current Diet: Excellent Good Fair Poor
 Are there any food allergies/sensitivities? Yes No

If so, explain: _____

Is your child active? Yes No moderately extremely

VISUAL HISTORY

Does one pupil ever appear to be larger than the other? Yes No

Do you ever notice one or both eyes shaking rapidly? Yes No

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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes "hurt" or "tired"	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motion sickness / car sickness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness of the eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

Do you feel your child's vision hinders his/her daily activities in any way? Yes No

If yes, how? _____

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"/>	_____
Closes or covers an eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty seeing distant objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head close to paper when writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Avoids/dislikes reading or other near tasks	<input type="checkbox"/>	<input type="checkbox"/>	_____

	<u>Yes</u>	<u>No</u>	<u>If yes, when</u>
Tilts head when reading or writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Moves head when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Confuses letters and words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reverses letters or words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Confuses right or left	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skips, omits words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loses place when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Uses finger as 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"/>	_____
Difficulty copying from the chalkboard	<input type="checkbox"/>	<input type="checkbox"/>	_____

Tires easily	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with short term memory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with long term memory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Short attention span/loses interest	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor / awkward large motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor / awkward fine motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dislikes/avoids sports	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty hitting / catching a ball	<input type="checkbox"/>	<input type="checkbox"/>	_____

PREVIOUS TREATMENTS

Has your child had a previous visual evaluation? Yes No
 Doctor's Name: _____ Date of Last Visit: _____

Results and recommendations: _____

Were glasses, contact lenses, or other optical devices ever prescribed? Yes No
 If yes, Bifocal: Single-vision: Contact lenses: Other: Explain: _____
 Are they used? Yes No
 If yes, when are they worn? _____
 If no, why not? _____

Has there been any treatment using an eye patch? Yes No
 If yes, please describe when the patching was started, how the patching was done, including the age it started, the eye patched, the duration of treatment, and an estimate of the results: _____

Have you ever been told that your child has amblyopia ("lazy eye")? Yes No
 Has there been any surgical treatment? Yes No
 If yes, please describe the surgery, including the age surgery was performed, the number of operations, the eye operated on, and an estimate of the cosmetic and subjective results: _____

Were you satisfied with the results of surgery? Yes No
 Please explain: _____

Was the surgeon satisfied with the results of surgery? Yes No
 Please explain: _____

Are you here for a second opinion regarding surgery or further treatment? Yes No
 Has there been any visual therapy? Yes No
 If yes, Drs. name: _____
 If yes, please describe the type of visual therapy, including its duration, the age at which it started, and an estimate of the results: _____

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: _____

Please give a brief description of your child as a person:

Is there any other information that would be important/useful 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, pediatrician, 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 other health care providers or insurance carriers upon their written request or upon the recommendation of the Omni Vision & Learning Center when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I authorize Dr. Gregory and the Omni Vision & Learning Center 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.

Parent's or Guardian's Signature

Date

I hereby give my permission to Omni Vision & Learning Center 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 to perform a more comprehensive evaluation of your child and to better meet your child's specific visual needs

If you have any questions or 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.

THANK YOU.

Sincerely,

Dr. Mary Gregory
Developmental Optometrist