



Children's Vision Questionnaire (For patient's 14 years or younger)

Please fill out this questionnaire carefully and bring with you on the day of your appointment. Thank you.

Appointment Date: _____ Time: _____

General Information

Patient's Name:		Date Of Birth: / /		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent/Guardian's Name:			Email Address:		
Home Phone Number:	Cell Phone Number:	Daytime Phone Number:	Emergency Phone Number:		
Home Address:		Apartment P.O. Box	City:	State:	Zip Code:
Name and Address of School:				Grade:	
Teacher(s):			Is your child especially afraid of doctors?		

Health History

Do <u>you</u> or any blood relative have <u>health</u> disorders?						<input type="checkbox"/> No known health conditions					
F: Father M: Mother S: Sibling-sister/brother GP: Grandparent											
	You	Family Member					You	Family Member			
Allergies (seasonal, environmental)	<input type="checkbox"/>	M	F	S	GP	Hepatitis	<input type="checkbox"/>	M	F	S	GP
Arthritis	<input type="checkbox"/>	M	F	S	GP	Herpes Simplex/Herpes Zoster/Shingles	<input type="checkbox"/>	M	F	S	GP
Blood/Lymph (anemia, sickle cell)	<input type="checkbox"/>	M	F	S	GP	High Blood Pressure	<input type="checkbox"/>	M	F	S	GP
Bleeding tendency	<input type="checkbox"/>	M	F	S	GP	HIV Positive (AIDS)	<input type="checkbox"/>	M	F	S	GP
Breathing problems	<input type="checkbox"/>	M	F	S	GP	Hormonal/Thyroid Disorder	<input type="checkbox"/>	M	F	S	GP
Cancer	<input type="checkbox"/>	M	F	S	GP	Immunologic (lupus, etc)	<input type="checkbox"/>	M	F	S	GP
Cardiovascular (heart, vessels, etc)	<input type="checkbox"/>	M	F	S	GP	Keloids (poor wound healing)	<input type="checkbox"/>	M	F	S	GP
Cholesterol	<input type="checkbox"/>	M	F	S	GP	Muscles, Bones, Joints (arthritis, etc)	<input type="checkbox"/>	M	F	S	GP
Collagen Vascular Disease, Lupus	<input type="checkbox"/>	M	F	S	GP	Neurological (Multiple Sclerosis, etc)	<input type="checkbox"/>	M	F	S	GP
Diabetes	<input type="checkbox"/>	M	F	S	GP	Nose, Sinus, Throat (infection, fever, cough)	<input type="checkbox"/>	M	F	S	GP
Fatigue	<input type="checkbox"/>	M	F	S	GP	Psychiatric (anxiety, depression, insomnia)	<input type="checkbox"/>	M	F	S	GP
Fever Blisters/Cold Sores	<input type="checkbox"/>	M	F	S	GP	Respiratory (asthma, bronchitis, emphysema)	<input type="checkbox"/>	M	F	S	GP
Gastrointestinal (stomach, bowel)	<input type="checkbox"/>	M	F	S	GP	Skin conditions (acne, warts, skin cancer)	<input type="checkbox"/>	M	F	S	GP
Genital, Kidney, Bladder	<input type="checkbox"/>	M	F	S	GP	Thyroid	<input type="checkbox"/>	M	F	S	GP
Headaches/Migraines	<input type="checkbox"/>	M	F	S	GP	Tuberculosis	<input type="checkbox"/>	M	F	S	GP

Hearing Impairment M F S GP

Weakness/Numbness/Arms/Legs M F S GP

Heart (cardiovascular) disease M F S GP

Weight Gain/Weight Loss M F S GP

Medical History

Pediatrician's name: _____ Date of last visit: _____

List all medications and conditions treated:

Medications	Conditions	Allergies

Developmental History

Full-term pregnancy? Yes / No

Did the mother experience any health problems during 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: _____

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

If yes, why: _____

Did you child crawl? Yes / No At what age? _____

At what age did your child walk? _____

Speech: First words at what age: _____

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 evaluation: _____

Results and recommendations: _____

Were glasses, contact lenses, or other optical devices recommended? Yes / No

If yes, what? _____

Are they currently used? Yes / No If yes, when? _____

Present Situation

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

How long has this difficulty been observed? _____

Have you received evidence from the school, psychological, or other tests that indicated some visual malfunction? Yes / No

If yes, please explain? _____

Does your child report any of the following:

If yes, when

___ Headaches _____

___ Blurred vision/focus goes in and out _____

___ Double vision _____

Eye hurt, itch or burn _____
 Eyes tired _____
 Words move around on the page _____
 Other _____

Have you or anyone else ever noticed the following If yes, when

Frequently red eyes _____
 Frequent eye rubbing _____
 Frowning or squinting or frowning _____
 Light sensitivity _____
 Head close to paper when reading/writing _____
 Avoids reading _____
 Tilts head when reading/writing _____
 Confuses letters or words _____
 Reverses letters or words _____
 Confuses right and left _____
 Skips, rereads or omits words or sentences _____
 Poor printing or handwriting _____
 Poor reading comprehension _____
 Short attention span _____
 Difficulty copying from the board _____
 Remembers better what they hear than see _____
 Fails to remember same word in next sentence _____

School

Age at entrance to Pre-School:	Kindergarten:	First Grade:
Has a grade been repeated? Yes / No		Has your child had any special tutoring, therapy, and or remedial assistance: Yes / No
Specifically describe any school difficulties: _____ _____ _____		If yes, when? _____ Where from? _____

Insurance

Vision Insurance Company			
Name of Insurance Company-Vision	Group Name:	Group Number:	Insured Id Card Number:
Name of policy holder-Member	Member D.O.B.	Member Social Security Number:	Insurance Co. Telephone Number:
Relationship to patient:	Member Employer:	Member Work Phone Number:	Mobile Telephone:
Medical Insurance Company			
Name of Medical Insurance Co:	Policy Holder Name (Employee):	Policy Holder Social Security Number:	Relationship to patient:
Group Name:	Group Number:	ID Number:	Insurance Company Phone Number:

About Your Eye Examination

Several procedures are required to examine the health of the eye and determine treatment and/or the prescription for your eyewear. The comprehensive examination and/or any other procedure generally require the instillation of eye drops to dilate the pupil of the eye. Dilating drops allow the doctor to examine the structures inside the eye. These drops may result in light sensitivity, hazy vision and difficulty focusing at near, for a duration of four (4) to ten (10) hours. Please exercise caution while driving, operating equipment, or reading during the duration of these effects.

I acknowledge the importance of dilating drops, as well as, understand the effects on my vision and wish to **ACCEPT/DECLINE** the use of dilating drops.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative)