PRAIRIE VISION

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CHILDRENS VISION QUESTIONNAIRE- EXTENDED

Please fill out this questionnaire carefully. Please return it to our office at your next scheduled 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: _____ Male/ Female

Birth Date: _____ Age: _____ years _____ months

Name of School: _____

Grade: _____ Teacher: _____ 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

Father's Name: _____ Mother's Name:_____

Daytime Phone:_____ Evening Phone:_____

Cell Number:_____

Email Address:_____

Medical History

Medical Doctors Name:_____ Date of Last Evaluation: _____

For what reason? _____

Results and recommendations:

_____

Child's current state of health: _____

Current Medications including vitamins and supplements:

_____

For what conditions?_____

Has your child had any reactions to immunizations? Yes No If so explain:

_____

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

Age Severe Mild Complications

_____

_____

_____

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	O	O	_____	High blood pressure	O	O	_____
"cross" or "wall" eye	O	O	_____	Learning disability	O	O	_____
Chromosomal imbalance	O	O	_____	Amblyopia (lazy eye)	O	O	_____
Glaucoma	O	O	_____	Multiple Sclerosis	O	O	_____
Epilepsy or Seizures	O	O	_____	Other	O	O	_____

If Other, please explain: _____

_____

Nutritional Information

Current Diet: Excellent O Good O Fair O Poor O

Does your child: Like sweets O or crave sweets O

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 at 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 by whom? _____ 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?

Name	Age	Visual Situation

Present Situation

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

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?

Headaches	Yes	No	When: _____
Blurred vision	Yes	No	When: _____
Focus going in and out	Yes	No	When: _____
Double Vision	Yes	No	When: _____
Eyes hurt	Yes	No	When: _____
Eyes tired	Yes	No	When: _____
Words move on the page	Yes	No	When: _____
Motion sickness/car sick	Yes	No	When: _____
Dizziness	Yes	No	When: _____

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

_____

Have you or anyone else ever noticed the following?

Eyes frequently reddened	Yes	No	When: _____
Frequent eye rubbing	Yes	No	When: _____
Frequent sties	Yes	No	When: _____
Bothered by light	Yes	No	When: _____
Frequent blinking	Yes	No	When: _____
Closing or covering one eye	Yes	No	When: _____
Difficulty seeing distant objects	Yes	No	When: _____
Head close to paper when reading or writing	Yes	No	When: _____
Avoids reading	Yes	No	When: _____
Prefers being read to	Yes	No	When: _____
Tilts head when reading or writing	Yes	No	When: _____
Moves head when reading	Yes	No	When: _____
Confuses letter or words	Yes	No	When: _____
Reverses letter or words	Yes	No	When: _____
Confuses right and left	Yes	No	When: _____
Skips, rereads or omits words	Yes	No	When: _____
Loses place while reading	Yes	No	When: _____
Vocalizes when reading silently	Yes	No	When: _____
Reads slowly	Yes	No	When: _____
Uses finger as a marker	Yes	No	When: _____
Poor reading comprehension	Yes	No	When: _____
Comprehension decreases over time	Yes	No	When: _____
Writes or prints poorly	Yes	No	When: _____
Writes neatly but slowly	Yes	No	When: _____
Awkward or immature pencil grip	Yes	No	When: _____
Frequent erasures	Yes	No	When: _____
Tires easily	Yes	No	When: _____
Difficulty copying from the chalkboard	Yes	No	When: _____
Difficulty recognizing same word on different page	Yes	No	When: _____

Poor word attack skills	Yes	No	When: _____
Difficulty with memory	Yes	No	When: _____
Remember better what hears than sees	Yes	No	When: _____
Responds better orally than by writing	Yes	No	When: _____
Seems to know material but does poorly on tests	Yes	No	When: _____
Dislikes/avoids near tasks	Yes	No	When: _____
Short attention span/loses interest	Yes	No	When: _____
Poor large motor coordination	Yes	No	When: _____
Poor fine motor coordination	Yes	No	When: _____
Difficulty with scissors/small hand tools	Yes	No	When: _____
Dislikes/avoids sports	Yes	No	When: _____
Difficulty catching/hitting a ball	Yes	No	When: _____

Television Viewing/Leisure time activities

Does child watch TV? Y N How much? _____ How often? _____ Viewing distance? _____

Does your child spend time using computer/video games? Y N 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 difficulties: _____

_____

Has your child changed schools often? Yes No If yes, when? _____

Has a grade been repeated? Yes No If yes, when? _____

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 and his/her peers? _____

_____

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 (please circle)? Mother Father Stepmother Stepfather Foster Parents Adoptive Parents Grandmother Grandfather Aunt Uncle

Other caretaker: _____

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 ongoing? 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? _____

Does anyone in the immediate or extended family have learning problems? Yes No

Please explain: _____

_____

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?

_____
_____
_____
_____
_____
_____
_____