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New Patient Pediatric Vision Questionnaire

Full Legal Name: ________________________ Date of Birth: ___ / ___ / ___ Age:______
Name your child prefers to go by: ____

GENERAL INFORMATION
Were you referred to our office? Yes No
By whom? ________________________ His/Her profession: ________________
Referral address: ________________________ Referral phone #: ____________
May we update this referral source? Yes No

Name and address of school: ____
Grade: ______________ Teacher's name: ________________________________

Name(s) of parents or responsible guardian(s): ____________________________
____

PRESENT SITUATION
Why does your child need a vision evaluation? ____________________________
____

Do you have any concerns about your child's eyes/vision: Yes No
If yes please explain: ____
____

Has the school/another professional expressed concern regarding your child's vision? If so, what concern: ____
____

Vision History
Has your child had an eye exam before? Yes No
Doctor's name: ________________________ Date of last eye exam: ____________
Were there significant results and/or recommendations? If so, explain: ____________
____

Does your child wear glasses or contact lenses? If so, what: ____________________
Are they used? Yes No If yes, when? ____________________
If not used, why not? ____________________

Has your child had eye surgery? Yes No
Procedure: ____________ Surgeon: ____________ Date: ________
Procedure: ____________ Surgeon: ____________ Date: ________

Has anyone in your child's family had any eye or vision problems?

Relationship	Eye Condition
____________	____________
____________	____________

MEDICAL HISTORY

Pediatrician's name and address ____________________
____

May we update your pediatrician? Yes No

Were there any complications during the pregnancy and/or birth? Yes No
If yes, explain: ____________________
____

Has your child had any significant illnesses, injuries, or hospitalizations? Yes No
If yes, explain: ____________________
____

Has your child had any surgeries? Yes No
Procedure: ____________ Surgeon: ____________ Date: ________

List all medications your child takes: ____________________

Any environmental or medication allergies: Yes No
If yes, explain: ____________________

DEVELOPMENTAL HISTORY

Is your child developmentally delayed or have special needs? Yes No
If yes, explain: ____________________
____
Is your child verbal or non-verbal? ____________________
Does your child use a wheelchair, walker, or other mobility aid? ____________

Is your child enrolled in physical, occupational, speech, or other developmental therapies?
If yes, what? ____________________
Location and frequency? ____________________

HOBBIES

What does your child like to do for fun? ____________________