Patient Questionnaire

Name_____Nickname_____Date of Birth_____
School_____Grade_____
Parents' names_____

My Child is here today because:_____
_____
_____
_____
_____

Who first noticed possible visual difficulties and when did they start ?_____
_____

Who referred you to our office?_____

Visual History

1) Is this your child's first eye examination? Yes___No___If not, when and where was their last examination?_____
2) Please describe any previous eye or visual problems, and the treatment your child has received (including glasses, vision therapy, patching, surgery, medication)._____
_____
_____

3) Please check any of the following that you have noticed or that your child complains about:

__blurred distance vision
__blurred vision during reading
__double vision
__words moving or running together on a page
__closes or covers one eye during reading
__tilts head
__frequent headaches
__fatigue during near visual tasks

__ falls asleep when reading
__ eye strain
__holds book or paper too close
__red or teary eyes
__avoids close work
__excessive blinking, eye rubbing or squinting
__loss of place while reading
__skips or rereads lines
__uses finger or place keeper to keep place with reading
__difficulty copying from the board
__reading comprehension decreases over time
__frequent reversals
__transposition errors in reading and spelling
__poor eye-hand coordination
__poor depth perception/sports performance
__poor self esteem and confidence in school
__behavior problems in school
__short attention span

Educational History

1) Has your child repeated any grades? Yes___ No___ If yes which one?
2) Is your child receiving any tutoring, extra help or special classes in school?
_____
_____
_____
3) Have there been any evaluations done (psychological, learning, speech/language, occupational therapy, neurological, medical)?_____
_____

4) Please check if your child has difficulties in any of the following areas:

__ reading
__spelling
__handwriting
__behavior or motivation
__copying from the board
__math
__attention span

5) Please check if any of the following aspects of reading are difficult or are behaviors you have noted during reading:

__comprehension
__avoidance
__omits small words
__fatigue
__slow reading
__word recognition
__phonics

6) Do you feel your child is performing up to their potential in school? Yes___ No__

7) Does your child enjoy reading for pleasure? Yes__ No__

Developmental History

1) Were there any complications with pregnancy or during birth? Yes__ No__
   If yes, please
   describe_____
   _____
2) Was your child born prematurely? Yes__ No__ If yes, how soon?_____
3) What was your child's birth weight? _____ Apgar Score_____
4) When did your child begin walking unassisted? _____
5) When did your child begin to talk?_____

Medical History

1) Has your child had any severe childhood illnesses, hospitalizations, injuries, or physical impairments? Yes___ No__
   If yes describe_____
   _____
2) Any current health problems? Yes__ No__
   If yes describe_____
   _____
3) Is your child taking any medications? If so please list_____
   _____
4) Any significant allergies? _____
5) Who is your child's pediatrician or primary doctor?_____
6) When was your child's last physical examination?_____

Family History

Does anyone in the family have any of the following?

| | Relationship to child |
|---|---|
| __strabismus (crossed eyes) | _____ |
| __amblyopia (lazy eye) | _____ |
| __learning or reading problems | _____ |
| __ blindness | _____ |
| __ eye disease(please list) | _____ |

_____