Children's Vision Questionnaire

Child's name:_____ Goes by:_____

Male __ Female __ Date of birth:_____ Age:_____years_____months

Address:_____

City:_____ State:_____ Zip:_____

School Name and address:_____

Child's grade in school:_____ Teacher:_____

Were you referred to our office? Yes No If yes, who referred you?_____

Mother's name:_____Father's name:_____

Guardians: _____

Child resides with: _____ Home phone:_____

Cell phone:_____ E-mail address_____

MEDICAL HISTORY

Pediatrician's Name: _____

Medications currently using, including vitamins and supplements: _____

_____

For what condition(s)?_____

_____

Any allergies to medications? _____

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

If yes, please list: _____

Has your child been diagnosed on the autism spectrum? Yes No

Does your child have a seizure disorder? Yes No Does your child have a sleep disorder? Yes No

Has a neurological evaluation been performed? Yes No

Has an occupational / speech / physical therapy evaluation been performed? Yes No

By whom? _____ Results and recommendations:

_____

Please list the relationship of any family member with a history of:

Diabetes _____ High Blood Pressure _____

"Cross"/"Wall" eye _____ Learning Disability _____

Chromosomal Imbalance _____ Amblyopia (lazy eye) _____

Thyroid Condition _____ Epilepsy or Seizures _____

Glaucoma _____ Multiple Sclerosis _____

Macular Degeneration _____ Autism Spectrum Disorder _____

If other, please explain:_____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes No Did the mother experience any health problems during the pregnancy? Yes No

If yes, explain: _____

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 a 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 your 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, Doctor's Name:

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? _____

Parent/ Guardian Signature: _____Date:_____