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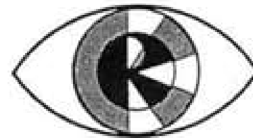

Please fill out this questionnaire <u>carefully</u>. Please return it to our office <u>prior</u> to your appointment.

Appointment: Day ________ Date ______________ Time ____________

A. GENERAL INFORMATION

CHILD'S FULL NAME ______________ Present age _____ Birthdate ________
Due date ________

Referred by: ____

HOME: Father ___________________________ Birthdate ________

Mother ___________________________ Birthdate ________

Brothers ___________________________ Birthdate ________
and ___________________________ Birthdate ________
Sisters ___________________________ Birthdate ________

B. PARENT INFORMATION

Home address ____________________ City ______________ Zip ________
Occupation ____________________ Home phone ____________________
Employer ____________________ Business phone ____________________
Business address ____________________ City ______________ Zip ________
Spouse occupation ____________________ Business phone ____________________
Employer ____________________ Business address ____________________
Do you have Major Medical Insurance? ______________________________
If so, who is the carrier? ______________________________
Policy # __________

C. MEDICAL HISTORY

Most recent medical examination: ______________________________
Doctor's name Date

____
Results

Medications currently using ______________________________
for what condition? ______________________________
Birth weight ____________
Did the Mother experience any health problems during the pregnancy, especially during the first trimester?
If yes, Please explain: ______________________________
____
____

C. MEDICAL HISTORY (continued)

List illnesses, bad falls, high fevers, etc.

Age	Mild	Severe	Complications

Is your child generally healthy? ____________________
Are there any chronic problems like asthma, hay fever, allergies? ______
If so, please list ____________________

____

Has a Neurological Evaluation been performed? ____________________
By whom? ____________________ Results ____________________
Any history in your family of the following?

Diabetes	________	Glaucoma	________
High blood pressure	________	Strabismus	________
Multiple sclerosis	________	"Cross" or "Wall" eye	________
Chromosonal imbalance	________	Amblyopia (lazy eye)	________
		Other	________

If other, please explain ____________________

D. DEVELOPMENTAL HISTORY

Full term pregnancy? _____ Normal Birth? ______ Any complications before, during or immediately following delivery? ____________________

____

____

Was there ever any reason for concern over your child's general growth or development? Yes___ No___ (If so, why?) ____________________

____

Where appropriate, list your child's age when he/she could do the following:

______	responsive smile	______	walked alone
______	crawl (stomach on floor)	______	scribbled spontaneously
______	rolled over	______	kicked a ball
______	creep (stomach off floor)	______	walked up steps with help
______	sat up alone	______	gave first name
______	responded to words or names	______	used two-word sentences
______	said single words	______	became toilet trained
______	stacked blocks	______	put on some clothing alone

What percent of the waking hours is your child in a playpen ______, walker ______, or seat ______?
What things can your child do very well? ____________________

____

What things, if any, are difficult for your child? ____________________

____

E. NUTRITIONAL INFORMATION

Current Diet: Nursing: never _______ now _______ nursed until _______

Solid food started ________ What type ___________

Activity Level: High ________ Moderate ______ Low ______________

Are there periods of very high energy? ______________

Are there periods of very low energy? ______________

F. VISUAL HISTORY

Previous examination: ____

Doctor's Name Date

Reason for examination: ____

Results: ____________________ Was therapy recommended? ________________

What type of therapy? _____________ (vision therapy, patching, surgery, glasses, contacts, etc.)

Members of the family who have had visual attention and why:

Name Age Visual Situation

____

____

____

* Please check "yes" or "no" to the following observations and/or complaints as they relate to your child:

	Yes	No
1. Eyes crossed - turning in or out - at any time, or eyes that do not appear straight, especially when child is tired	_____	____
2. Has reddened eyes or eyelids	_____	____
3. Has encrusted eyelids	_____	____
4. Has frequent sties	_____	____
5. Eyes in constant motion	_____	____
6. Eyelids droop	_____	____
7. Complains of headache	_____	____
8. Complains of burning or itching eyes	_____	____
9. Complains of pain in eyes	_____	____
10. Stares at bright lights frequently or repeatedly flicks objects in front of face	_____	____
11. Is abnormally bothered by bright light	_____	____
12. Has watery eyes	_____	____
13. Thrusts the head forward or backward while looking at distant objects	_____	____
14. Turns the head to use one eye only	_____	____
15. Tilts the head to one side	_____	____
16. Places an object close to the eyes to look at it	_____	____
17. Squints while looking at objects	_____	____
18. Blinks excessively	_____	____
19. Has a tendency to rub eyes	_____	____
20. Covers or closes one eye	_____	____

21. Stumbles over objects .... _____ _____
22. Lacks interest in looking at objects or seeing .... _____ _____
23. Unable to see distant objects .... _____ _____
24. Transfers object from hand to hand, crossing the middle of his body.................................... _____ _____

25. Is unable to stack blocks or other objects .... _____ _____

G. BEHAVIOR

	Yes	No
Do you have any concerns about your child's behavior?	_____	_____

If so, what are they? ____
____

Check the appropriate spaces if you have any concerns about the following behavior(s) in your child:

_____ lack of curiosity
_____ thumbsucking
_____ nervous
_____ glum, sulky, moody
_____ bad temper
_____ irritable, easily upset
_____ restlessness
_____ has difficulty separating from parents
_____ sleeplessness

Thank you for carefully completing this questionnaire.

The information supplied will allow for a more efficient use of time and will permit us to make a more complete evaluation of your child's visual system related to his/her specific needs.

Please be on time for your examination.

Thank you,