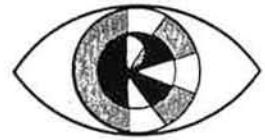


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Please fill out this questionnaire carefully. Please return it to our office prior to your appointment.

Appointment: Day _____ Date _____ Time _____
Patient's name: _____

A. GENERAL INFORMATION

CHILD'S FULL NAME _____ Present age ____ Birthdate ____
Name and address of School _____
Grade ____ Teacher _____ School Nurse _____ Principal _____
Is your child especially afraid of doctors? _____
Child's handedness - right or left? _____
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 _____
Business address _____ Employer _____
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? _____

Any history in your family of the following?
Diabetes _____ Glaucoma _____ High Blood Pressure _____

C. MEDICAL HISTORY (continued)

List illnesses, bad falls, high fevers, etc.

<u>Age</u>	<u>Severe</u>	<u>Mild</u>	<u>Complications</u>
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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 _____

Has a Psychological Evaluation been performed? _____

By whom? _____ Results _____

D. NUTRITIONAL INFORMATION

Current Diet: Excellent _____ Good _____ Fair _____ Poor _____

Does your child like _____ crave _____ sweets?

Is your child Active _____ Moderately _____ Extremely? _____

Are there periods of very high energy? _____ low energy? _____

E. DEVELOPMENTAL HISTORY

Full term pregnancy? _____ Normal birth? _____ Any complications before, during or immediately following delivery? _____

Did your child crawl (stomach on floor)? _____ Age _____

Creep (stomach off floor?) _____ Age _____ All fours? _____ If not, describe _____

At what age did your child walk? _____

Was child active? _____

Speech: First words at age _____ Was early speech clear to others? _____

_____ Is it clear now? _____

F. VISUAL HISTORY

Previous examination: _____

Doctor's Name

Date

Reason for examination: _____

Results: _____

Were glasses prescribed? _____ Are they worn? _____ When _____

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

Name

Age

Visual Situation

G. PRESENT SITUATION

Is there any evidence from the school or psychological tests that some visual malfunction may be present? _____ If so, what? _____

G. PRESENT SITUATION (continued)

Does your child report any of the following:

Headaches	Yes	___	No	___	When?	_____
Blurred vision	Yes	___	No	___	When?	_____
Double vision	Yes	___	No	___	When?	_____
Eyes "hurt" or "tired"	Yes	___	NO	___	When?	_____

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

Have you ever noticed the following? Yes No If so, when?

Eyes frequently reddened	_____	_____	_____
Frequent eye rubbing	_____	_____	_____
Frequent blinking	_____	_____	_____
Closing or covering one eye	_____	_____	_____
Head close to paper when reading or writing	_____	_____	_____
Tilting head when reading	_____	_____	_____
Tilting head when writing	_____	_____	_____
Moves head when reading	_____	_____	_____
Confuses letters or words	_____	_____	_____
Reverses letters or words	_____	_____	_____
Skips, rereads or omits words	_____	_____	_____
Vocalizes when reading silently	_____	_____	_____
Reads slowly	_____	_____	_____
Uses finger as a marker	_____	_____	_____
Poor reading comprehension	_____	_____	_____
Writes or prints poorly	_____	_____	_____
Tires easily	_____	_____	_____
Avoids near tasks	_____	_____	_____
Short attention span	_____	_____	_____
Poor motor coordination	_____	_____	_____
Difficulty catching/hitting a ball	_____	_____	_____

Television Viewing
 How much _____ How often _____ Viewing distance _____

H. SCHOOL

Age at time of entrance to Kindergarten _____ First Grade _____
 Does child like school? Yes ___ No ___ Teacher? Yes ___ No ___
 School work is: Above average _____ Average _____ Below average _____
 Do you feel (s)he is working up to potential? _____
 Does teacher feel s(he) is working up to potential? _____
 What school subjects easy for child? _____
 What school subjects difficult for child? _____
 Does child like to read? _____ Voluntarily? _____ What? _____
 Specifically describe any school difficulties: _____

Has a grade been repeated? Yes ___ No ___ Which? _____
 Has (s)he changed schools often? _____ When? _____
 Does (s)he seem to be under tension or extreme pressure when doing
 school work? _____
 Has (s)he had any special tutoring and/or remedial assistance? _____
 When: _____ From whom? _____ Where? _____
 How long? _____ Results: _____
 What is the child's attitude toward reading, school, his teachers,
 other youngsters? _____
 How well developed is his spoken vocabulary? _____

I. GENERAL BEHAVIOR

Are there any behavior problems? School _____ Home _____
What causes these problems? _____
Child's reaction to fatigue? Sag _____ Irritable _____ Other _____
Child's reaction to tension? Nail biting _____ Thumb sucking _____ Other _____
Does (s)he say and/or do things impulsively? _____ In constant
motion _____ Can't sit still for long periods? _____

J. FAMILY AND HOME

How does (s)he get along with:

Parents? _____

Siblings? _____

Classmates in school? _____

Playmates at home? _____

Did father or anyone in father's family have a learning problem? _____
Who? _____

Did mother or anyone in mother's family have a learning problem? _____
Who? _____

Is there any history of mental retardation, psychological disturbance,
etc., on either side of the family? _____ Who? _____

Do any, or did any, of the other children in the family have learning
problems? Who? To what extent? _____

K. GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON: