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Questionnaire for Pediatric Patients

Today's Date _____ **Child's Name** _____ **DOB** _____

Age _____ **Grade** _____ **F** ☐ **M** ☐ ☐ **Referred by** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Email** _____

Parents' Names – Parent 1: _____ **Parent 2:** _____

Occupations – Parent 1: _____ **Parent 2:** _____ **Marital Status: Married** ☐ **Single** ☐ **Divorced** ☐

Patient's Previous Diagnosis: _____

Reason for your child's visit (including any visual symptoms your child is experiencing):

When did the problem(s) start?

Visual History

Is this your child's first visual examination? Yes ☐ No ☐ If no, when was his/her last examination?

Who is your child's primary eye doctor? Name:

Address:

Phone:

Please describe any previous eye or vision problems and visual treatment your child has received (including glasses, vision therapy, patching, surgery, or medications).

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

☐ blurred distance vision	☐ squints or blinks excessively	☐ reverses numbers and letters
☐ blurred vision during reading	☐ rubs eyes during reading	☐ transposes numbers and letters
☐ double vision	☐ skips or rereads words and lines	☐ mistakes words w/ similar beginnings
☐ fatigue during near visual tasks	☐ loss of place when reading	☐ trouble learning right from left
☐ words moving or running together	☐ head movement when reading	☐ trouble learning basic math concepts
☐ eye strain	☐ uses finger or underliner to read	☐ poor recall of visual material
☐ frequent headaches	☐ red or teary eyes	☐ responds better orally than in writing
☐ eyes cross or drift in/out or up/down	☐ avoids near work	☐ excessive erasing
☐ closes one eye when reading	☐ poor depth perception	☐ sloppy writing skills
☐ holds reading material too close	☐ poor eye-hand coordination	☐ trouble copying from board to book
☐ turns or tilts head	☐ does not enjoy sports	☐ other (please describe)

Educational History

Do you feel your child is performing up to his/her potential in school? Yes ☐ No ☐

Has your child repeated any grades? Yes ☐ No ☐ If yes, which one?

Is your child receiving any tutoring, extra help, or special education classes in school? Yes ☐ No ☐ If yes, please describe.

Have there been any evaluations done at school or by school recommendation? (psychological, educational, speech/language, occupational therapy, neurological, hearing, or medical) Yes ☐ No ☐ If yes, please list name of professionals, tests performed, and briefly describe the results.

Please check if your child has difficulty in any of the following areas:

☐ reading	☐ handwriting	☐ motivation
☐ spelling	☐ copying from the board	☐ attention span
☐ math	☐ behavior	☐ homework takes longer than it should

Please check if any of the following aspects of reading are difficult or are behaviors you have noticed:

☐ phonemic awareness	☐ reading speed or fluency	☐ omits/confuses small words
☐ letter/word recognition	☐ comprehension	☐ fatigue/sleepiness
☐ phonics/decoding	☐ comprehension declines over time	☐ avoidance of reading

Does your child enjoy reading for pleasure? Yes ☐ No ☐

Developmental History

Were there any complications with pregnancy or during birth? Yes ☐ No ☐ If yes, please describe.

Was your child born prematurely? Yes ☐ No ☐ If yes, how early?

Was your child adopted? Yes ☐ No ☐

Does or did your child have any speech problems? Yes ☐ No ☐
Does or did your child have any problems with fine motor skills? Yes ☐ No ☐
Is your child clumsy or having any difficulty with activities requiring good balance? Yes ☐ No ☐
Does you child enjoy and participate in activities such as drawing, coloring, puzzles, block play, etc.? Yes ☐ No ☐

Medical History

Does your child suffer from any health problems, including any allergies or asthma? Yes ☐ No ☐ If yes, please describe.

Has your child had any severe childhood illnesses, injuries, or hospitalization? Yes ☐ No ☐ If yes, please describe.

Is your child taking any medications? Yes ☐ No ☐ If yes, please list:

When was your child's last physical examination?

Who is your child's pediatrician? Name:

Address:

Phone:

Family History

Does anyone in the family have any of the following?	Relationship to Child
☐ strabismus (crossed eyes or drifting eyes)	_____
☐ amblyopia (lazy eye)	_____
☐ high nearsightedness, farsightedness, or astigmatism	_____
☐ learning or reading problems	_____
☐ blindness	_____
☐ eye disease (please describe)	_____

Thank you for carefully completing this questionnaire.