CHILDRENS VISION QUESTIONAIRE

Please fill out this questionnaire carefully. Please return it to our office one week prior to your appointment in the self addressed stamped envelope provided. THANK YOU.

We're looking forward to evaluating your child in the near future. Please understand that a substantial period of time has been scheduled for this evaluation. **48 hours notice** is required if you need to cancel or reschedule for any reason to avoid a fee. The fee will be $50.00, for each appointment not cancelled or rescheduled. If you need to contact us please call 561-625-4380 and speak to one of our friendly staff members or leave a message after hours. Thank you for your understanding.

Appointment: Day:_____ Date:_____Time:_____
Patient's Name: _____

GENERAL INFORMATION

Were you referred to our office? Yes ☐ No ☐
If yes whom may we thank for this referral? _____
Phone: ( )_____Address:_____
Child's Full Name:_____M ☐ F ☐
Birth Date: _____Age: _____
Name of school: _____
Grade:_____ Teacher: _____School Nurse:_____
Child's dominant hand (circle) right or left?
Please list the names and birth dates of your family:
Father/Caretaker _____ Birth Date _____
Mother/Caretaker _____ Birth Date _____
Sibling _____ Birth Date _____
Sibling _____ Birth Date _____
Sibling _____ Birth Date _____

PARENT / GUARDIAN INFORMATION

Home Address: _____City: _____Zip:_____
Home Phone:( )_____Cell:( )_____Business:( )_____
Father/Caretaker's Occupation: _____ Business:( )_____
Business Address: _____ City:_____ Zip:_____
Mother/Caretaker's Occupation: _____Business Phone:( )_____
Business Address: _____City: _____Zip: _____
Do you have Vision Insurance? Y ☐ N ☐
If so, who is the carrier? _____Policy #: _____
Do you have Major Medical Insurance? Y ☐ N ☐
If so, who is the carrier? _____Policy #: _____
Name of Insured:_____
Social Security Number: _____

MEDICAL HISTORY

Pediatrician's Name: _____Date of Last Evaluation:_____
For what reason? _____
Results and recommendations:_____
_____
Child's current state of health:_____

Medications currently using, including vitamins and supplements:_____
_____
For what condition(s)? _____
_____
Has there been any illnesses, bad falls, high fevers, etc.:_____
_____
Is your child generally healthy? Yes □ No □, If no, explain:_____
_____

Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes ☐ No ☐
If yes, please list: _____
Has a neurological evaluation been performed? Yes □ No □ By whom? _____
Results and recommendations:_____
Has an occupational/physical/speech therapy evaluation been performed? Yes □ No □
By whom? _____Results and recommendations: _____
_____

Is there any history of the following? (Please check if there is a history.)

	Child	Family	Who		Child	Family	Who
Diabetes	☐	☐	_____	Glaucoma	☐	☐	_____
Multiple Sclerosis	☐	☐	_____	Amblyopia (Lazy eye)	☐	☐	_____
"Cross" or "Wall" eye	☐	☐	_____	Learning Disability	☐	☐	_____
Chromosomal Imbalance	☐	☐	_____	Epilepsy or Seizures	☐	☐	_____
Other	☐	☐	_____	ADD/ADHD	☐	☐	_____

If other, please explain: _____

NUTRITIONAL INFORMATION

Current Diet: Excellent □ Good □ Fair □ Poor □
Does your child: Like sweets □ or crave sweets □, If yes, what types?_____
Is your child active? Yes □ No □, Moderately? Yes □ No □ Extremely? Yes □ No □
Are there periods of? Very high energy? Yes □ No □ Very low energy? Yes □ No □
Please explain:_____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes □ No □
Did the mother experience any health problems during the pregnancy? Yes □ No □
If yes, explain:_____
Normal birth? Yes □ No □
Any complications before, during or immediately following delivery? Yes □ No □
If yes, explain:_____
Did/Does your child have any developmental or growth delays? Yes □ No □, If yes, explain :____
_____
Speech: First words: _____At what age:_____
Is speech clear now? Yes □ No □

VISUAL HISTORY

Has your child's vision been previously evaluated? Yes□ No □
If so, Doctor's Name: _____Date evaluated:_____
Reason for examination:_____Results and recommendations:_____
_____
Were glasses, contact lenses, or other optical devices recommended? Yes □ No □
Are they used: Yes □ No □ If yes, when? _____ If not used, why not? _____

PRESENT SITUATION

Why do you feel your child needs a visual evaluation? _____
_____
How long has this problem/difficulty been observed? _____
Is there any evidence from the school, psychological, or other tests that indicates some visual malfunction may be present?
Yes □ No□, If yes, what? _____

Does your child report any of the following?

	Yes	No	If yes, when?		Yes	No	If yes, when?
Headaches	□	□	_____	Eyes tired	□	□	_____
Blurred vision / focus goes in & out	□	□	_____	Double vision	□	□	_____
Words move around on the page	□	□	_____	Eyes hurt	□	□	_____
Motion sickness /car sickness	□	□	_____	Dizziness	□	□	_____

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

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING:

	Yes	No	When?		Yes	No	When?
Eyes frequently reddened	□	□	_____	Frequent sties	□	□	_____
Frequent eye rubbing	□	□	_____	Frowning	□	□	_____
Bothered by light	□	□	_____	Frequent blinking	□	□	_____
Closing or covering one eye	□	□	_____	Difficulty seeing distant objects	□	□	_____
Head close to paper when reading/writing	□	□	_____	Avoids reading	□	□	_____
				Tilts head when reading	□	□	_____
Prefers being read to	□	□	_____	Tires easily	□	□	_____
Tilts head when writing	□	□	_____	Moves head when reading	□	□	_____
Confuses letters or numbers	□	□	_____	Reverses letters or words	□	□	_____
Confuses right and left	□	□	_____	Skips, rereads or omits words	□	□	_____
Loses place while reading	□	□	_____	Reads slowly	□	□	_____
Vocalizes when reading silently	□	□	_____				

	Yes	No	When?		Yes	No	When?
Uses finger as a marker	□	□	_____	Frequent erasures	□	□	_____
Poor reading comprehension	□	□	_____	Writes or prints poorly	□	□	_____
Comprehension decreases over time	□	□	_____	Writes neatly but slowly	□	□	_____
Does not support paper when writing	□	□	_____	Awkward or immature pencil grip	□	□	_____
Difficulty copying from chalkboard	□	□	_____				
Poor word attack skills	□	□	_____	Difficulty recognizing same word	□	□	_____
Difficulty with memory							
On different page	□	□	_____	Responds better orally than by writing	□	□	_____
Remembers better what hears then sees	□	□	_____				
Seems to know material, but does				Dislikes / avoids near tasks			
Poorly on tests	□	□	_____		□	□	_____
Short attention span / loses interest	□	□	_____	Poor large motor coordination			
Poor fine motor coordination	□	□	_____	Dislikes / avoids sports	□	□	_____
Difficulty with scissors / small hand tools	□	□	_____	Difficulty catching / hitting a ball	□	□	_____

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

How often does your child watch TV? _____ Viewing distance_____
How often does your child spend time using computer/video games? _____
What other activities occupy your child's leisure time? _____
Are there any activities your child would like to participate in, but doesn't? _____
Please explain: _____
_____

SCHOOL

Age at entrance to: Pre-school _____Kindergarten _____First Grade_____

Does your child like school? Yes ☐ No ☐
Specifically describe any school difficulties: _____
_____

Has your child changed schools? Yes ☐ No ☐, If yes, when? _____

Has a grade been repeated? Yes ☐ No ☐, If yes, which and why? _____
_____

Does your child seem to be under tension or extreme pressure when doing school work?
Yes ☐ No ☐

Has your child had any special tutoring, therapy, and /or remedial assistance? Yes☐ No☐
If yes, when? _____From whom? _____How long? _____
Results: _____

Does your child like to read? Yes ☐ No ☐ Voluntarily? Yes ☐ No ☐

Does your child read for pleasure? Yes ☐ No ☐ What? _____
What is your child's attitude toward reading, school, his/her teachers, other youngsters?
_____

Overall schoolwork is: **Above average** ☐ **average** ☐ **below average** ☐
Which Subjects Are:
Above average: _____
Average: _____
Below Average: _____
Does your child need to spend a lot of time/ effort to maintain this level of performance?
Yes ☐ No ☐
How much time on average does your child spend each day on homework assignments?
_____
To what extent do you assist your child with homework? _____

Do you feel your child is achieving up to potential? Yes ☐ No ☐

Does the teacher feel your child is achieving up to potential? Yes ☐ No ☐

GENERAL BEHAVIOR

Are there any behavioral problems at school? Yes ☐ No ☐, If yes, what? _____

_____

Have any steps been taken to remediate the behavioral problems? _____

_____

Child's reaction to fatigue? Sag ☐ irritable ☐ other ☐ _____

Child's reaction to tension? Avoidance ☐ irritable ☐ other ☐_____

Does your child say and/ or do things impulsively? Yes ☐ No ☐

Is your child in constant motion? Yes ☐ No ☐

Can your child sit still for long periods? Yes ☐ No ☐

FAMILY AND HOME

Please indicate which adult(s) he/she lives with?

Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Foster Parents ☐ Adoptive Parents ☐

Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ Other Caretaker (please specify):

_____

Does your child spend time with any other person, not in the home? Yes ☐ No ☐

Please explain: _____

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? Yes ☐ No ☐, If yes, at what age: _____

Does your child seem to have adjusted? Yes ☐ No ☐, Was counseling /therapy undertaken? Yes ☐ No ☐, If yes, is it on-going? Yes ☐ No ☐

Is family life stable at this time? Yes ☐ No ☐**,** If no, Please explain: _____

_____

How does your child get along with:

Parents/other caretakers? _____

Siblings? _____

Playmates at home? _____

Playmates at school? _____

Does the father or anyone in father's family have a learning problem? Yes ☐ No ☐

If yes, who? _____

Does the mother or anyone in mother's family have a learning problem? Yes ☐ No ☐

If yes, who? _____

Do / did any of the other children in the family have learning problems?

Yes ☐ No ☐ If yes, who? _____

To what extent? _____

_____

IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL OR IMPORTANT IN OUR TREATMENT OF YOUR CHILD?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

AUTHORIZATION

I certify that I have read and accurately answered the above questions to the best of my knowledge. I understand that providing inaccurate information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such eye care to third party payers and/or health practitioners. I understand that copays or payments are expected in full at the time services are rendered. I also authorize and request my insurance company to forward payment to Dr. Shim's office for those services. If Dr. Shim is an out-of-network provider, I understand that my insurance may not cover or may pay less than the actual bill for services rendered. I agree to be responsible for payment of those services.

Guardian's Name_____
Please print First Last

Patient/Guardian Signature_____**Date**_____