Children's Vision Questionnaire

Pediatrician's Name: _____

Child's current state of health: _____

Medications currently using, including vitamins and supplements:
_____

For what condition(s)? _____
_____

Any allergies to medications? _____

List illnesses, bad falls, high fevers, etc:
Age Severe Mild Complications
_____
_____
_____

Is your child generally healthy? Y _____N _____
If no, explain: _____
Are there any chronic problems like ear infections, asthma, hay fever, allergies?Y__N__
If yes, please list: _____
Has you child been diagnosed on the autism spectrum? Yes _____ No _____
Has a neurological evaluation been performed? Yes _____ No _____
By whom? _____Results and recommendations: _____
_____
Has a psychological evaluation been performed? Yes ____No _____
By whom? _____Results and recommendations: _____
_____
Has an occupational/ speech/physical therapy evaluation been performed? Yes ___No__
By whom? _____Results and recommendations: _____
_____

Is there any history of the following? (please check)

	Patient	Family	Whom		Patient	Family	Whom
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	☐	☐	_____

NUTRITIONAL INFORMATION

Current Diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Does your child: Like sweets ☐ or crave sweets ☐
If yes, what types? _____
Are there periods of very high energy? Yes ☐ No ☐
Very low energy? Yes ☐ No ☐ Extreme activity? Yes ☐ No ☐
Explain:
_____
_____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes ☐ No ☐
Did the mother experience 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: _____
_____
Birth weight: _____
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? _____

Members of the family who have had visual attention and the reason:
Name: _____
Age: _____
Visual Situation: _____

Present Situation:

Why do you feel your child needs a visual evaluation?
_____
_____
_____

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Does child watch TV? Yes ☐ No ☐
If yes, how much? _____How often? _____Viewing distance? _____
Does your child spend time using computer/video games? Yes ☐ No ☐
If yes, how much? _____ How often? _____Viewing distance? _____
What other activities occupy your child's leisure time? _____
Can you child ride a bike? Yes ☐ No ☐ Swim? Yes ☐ No ☐
Are there any activities your child would like to participate in, but doesn't? Please explain:
_____
_____

GENERAL BEHAVIOR

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

Classmates in school?_____

Playmates at home? _____

Did parents or anyone in parent's family have a learning problem? Yes ☐ No ☐
If yes, who? _____ Date_____