CHILD EXAMINATION QUESTIONNAIRE FOR PARENTS

Today's Date_____

Child's full name _____ Nickname, or likes to be called_____

Date of Birth_____ Age: _____years and _____months Brothers/Sisters Age

Name of School_____ Grade_____ _____

School Address_____ Teacher_____

_____ School Nurse_____

Brief Summary of your main concerns_____

_____

_____

SCHOOL HISTORY

1. Age of entrance into kindergarten_____ first grade_____

2. Does your child like school: _____

3. Easiest subject(s): _____ 4. Hardest Subject(s): _____

5. Are there any school difficulties? If so, please describe them and when they began:

_____

_____

6. Has there been any remedial work? If yes, please give specifics:

_____

_____

7. Has a grade ever been repeated?_____ If so, which?_____

8. Has there ever been any psychological, educational, audiological or other testing performed?_____

If yes, please give specifics:_____

(please turn the page over and complete the other side)

GENERAL BEHAVIOR

Please place a check mark next to any of the following behaviors that you believe your child exhibits, and next to any problem that seems to occur often.

High activity level	
Poor attention span	
Impulsivity	
Frustrates easily	
Doesn't listen when spoken to	
Poor memory	
More active than other children his (her) age	

GENERAL HEALTH

1. Any significant illnesses? _____

If yes please specify _____

_____

_____

2. Is (s)he taking any medication? _____

If yes please specify _____

Previous Vision History

1. When was the last eye examination _____

By whom _____

2. Have glasses ever been prescribed? _____

If yes give specifics _____

_____

_____

3. Does anyone in the family have any vision problems? _____

If yes specify _____

_____

Signs of Eye Teaming Problems

Covers or closes one eye when reading	
Rubs eyes	
Child complains of eyestrain	
Child complains of headaches	
Child complains of double vision	
Child complains of words moving on the page	
Inattentive	
Poor reading comprehension	
Loses place	

Signs of Focusing Problems

Child complains of blurred vision	
Child complains of blurred vision when looking from desk to board	
Child complains of eyestrain	
Child complains of headaches	
Rubs eyes	
Inattentive	
Poor reading comprehension	
Is tired at the end of the day	
Holds things very close	

Signs of Tracking Problems

Loses place often	
Must use finger or guide to keep place	
Skips lines and words often	
Poor reading comprehension	
Short attention span	

Signs of Visual Processing Disorders

Trouble learning left from right	
Reverses letters and numbers	
Mistakes words with similar beginnings	
Can't recognize the same word repeated on a page	
Trouble learning basic math concepts of size, magnitude	
Poor reading comprehension	
Poor recall of visually presented material	
Trouble with spelling and sight vocabulary	
Sloppy writing skills	
Trouble copying from board to book	
Erases excessively	
Can't respond orally but not in writing	
Seems to know material but does poorly on written tests	

PERSONAL AND MEDICAL BACKGROUND INFORMATION

Patient Name _____ Date_____ Time _____

E-Mail _____ Height_____ Weight_____

1. The main reason/s for today's visit is / are: _____

   _____

2. When was your last: Eye Examination? _____ General Physical? _____

3. **MEDICAL HISTORY**: Please list ALL ...
   Medical problems (Diabetes, High Blood Pressure, Kidney Disease, Cancer, etc.)
   Medications that you are taking, and what you are taking them for:

   _____

   _____

4. Have you had any serious **EYE or HEAD** injuries, illnesses, or surgeries?

   _____

5. If you have headaches, please describe what part of the head, and how often, and when they began.

   _____

6. Is there anyone in your family that has had severe eye problems or health problems ?

   _____

7. Medical Insurance: _____ Has this changed? **Yes** **No**
8. Vision Plan: _____ Has this changed? **Yes** **No**

9. **OPTOMAP RETINAL EXAM:**
   The Optomap Retinal Examination is a picture of the retina (back part of the eye). No eyedrops.
   The advantages to you are:
   1. Fast (less than 1 second per eye) and there is No blurred vision afterwards.
   2. You are able to see the back part of your own eye, and have the doctor explain the findings.
   3. It is now part of your record, and allows us to compare the retina from year to year.

   This new technology is a part of our standard of care and the fee for this test is **$39.00**.
   This test is not covered by any medical insurance. I choose to have this test..... **Yes** **No**

10. Name of: Husband_____ Wife_____
    If patient is a child: Father_____ Mother_____
    Please list your children's names and their ages: _____

    _____

11. **The Comprehensive Examination** addresses eye health and eyeglass prescriptions.

12. **Contact Lens Examination:** There are 3 levels; standard, complex, and custom.
    The fee for this service is separate from the comprehensive examination.
    _____ initials

13. **Contact Lens Assessment** for individuals who are wearing Contact Lenses:
    This service (1) assesses the fit, positioning, power, corneal health, etc. with your contact lenses on, and then (2) assess your cornea and prescription (refraction) after removing your contact lenses. This additional testing is separate from a Comprehensive Examination. The fee for this assessment starts at **$25.00**.
    _____ initials

PLEASE TURN OVER – Continued on other side

	Yes	No
1 Are you interested in getting eyeglasses today?		
2 Are you interested in getting contact lenses?		
3 Is you child having school-related problems or difficulty reading?		
4 Are you having vision problems after LASIK or PRK?		
5 Are you having vision problems after Brain Injury? Crash, fall, etc.		
6 Are you interested in learning about a Non-Surgical method to correct your vision?		
7 Do you wear: [] Eyeglasses? [] Contact Lenses?		
8 Do you see clearly **at distance**, for example, driving or watching TV?		
Only if I wear my [] Eyeglasses? [] Contact Lenses?		
9 Do you see clearly **at near**, for example reading, sewing, computer?		
Only if I wear my [] Eyeglasses? [] Contact Lenses?		

10 Do your eyes []burn []Itch []feel dry []Have discharge [] tear or water excessively

11 Do your eyes feel []painful []achy []irritated as though there is something in your eyes

12 Do you ever see []double []floaters []flashes of light []sudden blurred or reduced vision

13 Are you bothered by []glare []smoke []allergies []bright sunlight []artificial lights []sinus problems

14 Occupation - what type of work do you do? _____

15 At work, do you... []sit []stand [] work above eye level []use computer extensively

16 Hobbies - what types of things do you like to do?

[] Near work such as reading, crosswords, cards, crafts [] other_____

17 What sports are you involved in?

[]basketball []golf []swim []tennis []racquetbali [] other_____

Family Eye Care
Dr. S. Moshe Roth, OD, FCOVD

Board Certified in Developmental Vision and Therapy
Fellow of College of Optometrists in Vision Development

Developmental and Behavioral Optometry
Treatment of Eye Disease
Orthokeratology
Vision Therapy

Name of Patient: _____

Health Insurance Claim Number (if applicable):_____

Social Security Number:_____

Insurance Payment and Coverage

- I request that payment of authorized Insurance, benefits be made either to me or on my behalf to Dr. S. Moshe Roth, OD for services furnished me by that physician.
- I authorize any holder of medical information about me to be released to the Insurance Administrator and its agents and authorize this office to obtain any information needed to determine benefits for related services.
- I understand that any insurance deductibles and co-payments are my responsibility. If, for any reason, my insurance company is unwilling to pay for services, or pays less that anticipated, I accept responsibility for those charges.
- I understand that some services offered at this office may not be covered under my insurance, such as Contact Lens Evaluation, Sensory Motor Evaluation, Low Vision Evaluation, etc.

Information Release

I authorize Dr. Roth to release information to, and discuss any medical history with other doctors, therapists, educators and insurance company representatives.

HIPPA Notice of Privacy Practice

I acknowledge that I received a copy of this office's Notice of Privacy Practice.

Financial Responsibility

- I understand that all payments are to be made at the time of services rendered.
- I understand that a fee of $5.00 per month will be added to any account balances, and that these service charges become my responsibility as well.
- I understand that a fee of $50.00 will be charged to my account if it is turned over to a Collection Agency.

Please indicate the method of payment of professional services:

[ ] Cash
[ ] Check
[ ] Credit Card (Master Card, Visa, Discover)
[ ] Care Credit, our monthly payment plan

Patient's Signature: _____ Date: _____

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