MILTON EYE CARE

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CHILDREN'S VISION QUESTIONNAIRE

Please fill out this questionnaire and return it to our office at the time or before your appointment. Thank you.

Child's full name: ______________________ Date of Birth: ______________

Address: ______________________ Phone number: ______________

______________________ Email: ______________

Parent/Caregiver name(s): ______________________

Were you referred to our clinic? ☐Yes ☐No

If yes, whom may we thank for this referral? ______________________

MEDICAL HISTORY

Family Doctor: ______________________ Allergies: ______________

Medical conditions: ______________________

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Medications (incl. vitamins/supplements): ______________________

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VISUAL HISTORY

Main reason for having an examination today? ______________________

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Date of last eye exam: ______________________ Optometrist: ______________

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

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Does your child wear his/her glasses? ☐Yes ☐No ☐N/A If yes, when? ______________

Do you observe or does your child report any of the following: (Please check all that apply)

☐ Headaches	☐ Double Vision	☐ Crossed or wandering eye
☐ Blurred Vision (near)	☐ Eyes hurt or tired	☐ Difficulty tracking an object
☐ Blurred Vision (far)	☐ Squinting	☐ Closes or covers one eye
☐ Head tilt	☐ Motion/car sickness	☐ Burning, itching or tearing
☐ Light sensitivity	☐ Eye injury or surgery	☐ History of wearing an eye patch
☐ Difficulties with memory	☐ Loses attention easily	☐ Focus goes in and out

Any other concerns about your child's vision? ______________________

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EDUCATIONAL HISTORY

Current school: ________________________________ Grade:

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

Is your child receiving any tutoring, extra help or special classes? ☐Yes ☐No

If yes, please describe: ____

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Has your child been diagnosed with a learning disability? ☐Yes ☐No If yes, when? ________________

Has your child been diagnosed with ADD or ADHD? ☐Yes ☐No If yes, when? ____________________

Has your child been diagnosed with Dyslexia? ☐Yes ☐No If yes, when? ____________________

Current academic levels:

	Above Grade	On Grade	Below Grade	Special Help
Reading				
Reading Comprehension				
Spelling				
Math				
Handwriting				

Academic concerns:

- ☐ Avoids reading
- ☐ Poor, inefficient reading
- ☐ Poor spelling
- ☐ Difficulty copying from the board
- ☐ Vocalizes when reading
- ☐ Uses finger to track along line when reading
- ☐ Poor handwriting
- ☐ Loses place while reading
- ☐ Holds book really close
- ☐ Math difficulty (facts/concepts)
- ☐ Confuses left and right
- ☐ Poor reading comprehension
- ☐ Skips, rereads or omits words/lines
- ☐ Frequent letter, number or word reversals
- ☐ Words moving on a page or running together

How much time each day, on average, does your child spend on homework/assignments? ________________

To what extent do you assist your child with his/her homework/assignments? ____________________

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

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

DEVELOPMENTAL HISTORY

Full-term pregnancy? ☐Yes ☐No If no, how premature? ________________

Were there any complications during pregnancy and/or delivery? ☐Yes ☐No

If yes, please explain: ____

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Birth weight: __________ Apgar score @ 1 min: ________ Apgar score @ 5 min: ________

When did your child begin walking unassisted? ________________________________

When did your child begin to say 2-3 word phrases? ________________________________

Any speech problems? ☐Yes ☐No Any problems with fine motor coordination? ☐Yes ☐No

Is your child clumsy? ☐Yes ☐No

Any other pertinent information? ____

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