VISION
PROFESSIONALS

PRE-EXAMINATION QUESTIONNAIRE
(CHILD)
Welcome to our practice!

Child's Name: **Birth Date:** / / **Date:** / /

Address:	**Person Responsible for Account:**
City / State / Zip:	Name:
Home Phone: ( ) -	Method of Payment: (circle)
Parent Cell Phone: ( ) -	Cash / Check / VISA / MC / Discover
Child Social Security #	Vision Insurance:
School/Grade:	Medical Insurance:
E-Mail:	Responsible Party Social Security #: - -

How did you hear about our practice? _____

If referred by a current patient, please write their name on the line above so we may thank them.

List family members below and indicate if they are patients in our office:

Family Member	Age	Patient (yes/no)
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____

Is there a specific reason you decided to get your child's eyes checked? _____

_____

Has your child ever had previous eyecare? When: _____ Whom: _____

Who is your child's physician/pediatrician? _____ Location: _____

EYE HEALTH & MEDICAL CONDITIONS

Circle Appropriate Answer			**If Yes, please explain with additional information**
Yes	No	Was your child born more than 30 days premature?	list weeks: birth weight:
Yes	No	Were there any pregnancy complications for child or mother?	
Yes	No	Was oxygen used after birth?	
Yes	No	Does your child have any developmental or neurological delays?	
Yes	No	Does your child have any medical conditions?	
Yes	No	Has your child ever worn glasses?	
Yes	No	Has your child been diagnosed with lazy eye or strabismus?	
Yes	No	Has your child ever worn an eye patch?	
Yes	No	Has your child had any form of vision therapy?	
Yes	No	Has your child ever had any eye injuries or accidents?	
Yes	No	Has your child ever undergone eye surgery?	
Yes	No	Do any relatives have any serious eye problems?	

Please list any medications or eyedrops your child uses: _____

_____

Please list any allergies your child has: _____

_____

Please list any other issues that may be pertinent to today's exam:

_____

_____

_____

Does your child complain of (check all that apply):

_____ blur with distance viewing	_____ watery eyes	_____ tired eyes
_____ blur when reading at near	_____ red or blood-shot eyes	_____ headaches
_____ squinting	_____ burning or itching	_____ nausea or dizziness
_____ words running or jumping together	_____ encrusted eyelids	_____ double vision
_____ eye ache, hurt or pull	_____ frequent styes	_____ eyes turn in / out
		_____ light bothering eyes

List any activities that your child is involved in. Include sports, hobbies, interests, etc.

_____

_____

Is your child's schoolwork (circle one): Below Expectations Satisfactory Very Good

Does your child have problems in any subjects? Reading Writing Spelling Math History Science

Have you or anyone else frequently noted the following behaviors in your child (check all that apply)?

Binocular Vision Signs / Symptoms	**Perceptual Signs / Symptoms**
_____ moves head rather than eyes while reading	_____ mistakes words with same or similar beginnings or endings
_____ loses place, rereads or skips lines while reading	_____ fails to recognize same word in next sentence
_____ uses finger marker to keep place while reading	_____ reverse letters and/or words in writing and copying
_____ displays short attention span while reading or copying	_____ fails to remember what he/she was read or told aloud
_____ writes up or down hill on paper	_____ says words aloud or lip reads while reading silently
_____ repeats letters within words when copying	_____ does not complete assignments
_____ omits numbers, letters or phrases	_____ uses excessive effort to achieve
_____ misaligns digits in number columns	_____ has difficulty with phonics
_____ squints, closes or covers one eye when working	_____ lacks motivation
_____ tilts head extremely while working at desk or reading	_____ confuses right and left
_____ holds book or work too close to face	_____ has short attention span
_____ blinks excessively at desk tasks and/or reading	_____ dislikes reading
_____ avoids near centered tasks	_____ is hyperactive
_____ makes errors copying from chalkboard to paper	_____ is easily distracted
_____ makes errors copying from one paper to another	_____ is easily frustrated
_____ rubs eyes during or after visual activity	_____ is sloppy when doing work
	_____ seems awkward / uncoordinated

Is your child interested in wearing contact lenses? Yes No

Does your child have a back up pair of glasses? Yes No

Does your child wear sunglasses? Yes No prescription? Yes / No

When you visit our practice you may be interested to know what we will do to ensure you clear, comfortable vision. We carefully examine your eyes to determine what lens correction, if any, is necessary to give you the vision you require for all the things you need to do. Second, we will conduct a binocular vision screening to determine how well your eyes work together as a team. Last but not least, we will perform a thorough examination of your eye health. We are sure you will recognize the importance of all these steps in order to provide you with great vision.

When we recommend eye care, we want you to fully understand the benefits that you can anticipate. Therefore, it is our policy to discuss with you the results of your eye examination and to make recommendations tailored to fit your personal needs.

During the examination:

1. Do not worry about making a mistake or giving a wrong answer.
2. Do not worry about your answers contradicting one another.
3. Do not be alarmed if for a few minutes your vision is getting worse instead of better.
4. Do not hesitate to tell the doctor if you are unable to answer his/her questions.

Parent / Responsible Party Signature: _____ Date _____