



#114, 506 St. Albert Trail  
St. Albert, AB  
T8N 5Z1  
780-419-7000

Child Patient Information

Name: \_\_\_\_\_ School: \_\_\_\_\_  
Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_  
Parent's Names: \_\_\_\_\_  
Who referred you to Eye Health Centre? \_\_\_\_\_

Patient History Questionnaire

Please fill out questionnaire carefully and return it to the office at the time of your appointment. The time spent answering questions will allow the doctor to better plan the flow of the examination procedures.

Thank you for your time and effort in completing this questionnaire. Leave blank or put N/A besides questions that do not apply.

PRESENT SITUATION AND SYMPTOMS

What are the concerns that prompted this functional vision evaluation?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have these concerns been observed? \_\_\_\_\_

What goals do you hope to accomplish from the functional vision evaluation and/or perceptual vision evaluation?

\_\_\_\_\_

In your opinion, is vision impacting academic performance? \_\_\_\_\_

Has your child expressed concerns regarding vision? \_\_\_\_\_

VISUAL HISTORY

Last Eye Exam (year) \_\_\_\_\_ Doctor: \_\_\_\_\_ City: \_\_\_\_\_

Were glasses, contact lenses or other optical devices prescribed or recommended? If so, what? and do you use them? If not using them, why?

\_\_\_\_\_  
\_\_\_\_\_

Explain any history of eye surgeries, eye/head injury, vision therapy or other treatments in the past (related or not to current concerns)

\_\_\_\_\_



# Quality of Life Checklist

Patient Name: \_\_\_\_\_  
 Form Completed by: \_\_\_\_\_  
 Date: \_\_\_\_\_

Check the column which best represents the occurrence of each symptom	Never 0	Seldom 1	Occasionally 2	Frequently 3	Always 4
Blurred close vision					
Double vision					
Headaches with near work					
Words run together reading					
Burning, itchy, watery eyes					
Falls asleep reading					
Sees worse at the end of day					
Skips/repeats lines reading					
Dizzy/nauseated by near work					
Head tilt/one eye closed to read					
Difficulty copying from chalkboard					
Avoids near work/reading					
Omits small words when reading					
Writes uphill/downhill					
Misaligns digits/columns of numbers					
Poor reading comprehension					
Poor/inconsistent in sports					
Holds reading too close					
Trouble keeping attention on reading					
Difficulty completing work on time					
Says "I can't" before trying					
Avoids sports/games					
Poor hand/eye coordination					
Poor handwriting					
Does not judge distance accurately					
Clumsy, knocks things over					
Poor time use/management					
Does not make change well					
Loses things/belongings					
Car or motion sickness					
Forgetfulness/poor memory					
Total for each column:	x 0 = 0	x1 =	x2 =	x3 =	x4 =

Grand Total:



<15 = Routine eye exam recommended

16-24 = Comprehensive exam with developmental OD recommended

>25 = Developmental vision problem likely, comprehensive exam with developmental OD strongly recommended

Any other symptom/concerns not mentioned in the previous checklist?

\_\_\_\_\_

**If your child has an eye turn, please fill out the following section:**

At what age did you notice the eye first turn? \_\_\_\_\_

Has your child had eye surgery? \_\_\_\_\_ If yes, reason? \_\_\_\_\_ Date? \_\_\_\_\_

Has your child had any treatment with a patch? \_\_\_\_ If yes, what was the schedule? \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

Full Term Pregnancy? \_\_\_\_yes \_\_\_\_ no

Normal Birth? \_\_\_\_ yes \_\_\_\_no If complications, explain \_\_\_\_\_

**Motor Development**

Did your child crawl (stomach on floor)? \_\_\_\_ yes \_\_\_\_ no At what age? \_\_\_\_\_

Did your child creep (on all fours)? \_\_\_\_ yes \_\_\_\_no At what age? \_\_\_\_\_

At what age did your child start to walk? \_\_\_\_\_

Did your child have difficulty learning to throw or catch a ball? \_\_\_\_ yes \_\_\_\_no

Did your child have difficulty learning to cut with scissors? \_\_\_\_ yes \_\_\_\_no

Did your child have difficulty learning to tie shoelaces? \_\_\_\_ yes \_\_\_\_no

Did your child have difficulty learning to ride a bicycle? \_\_\_\_ yes \_\_\_\_no

**SCHOOL HISTORY**

Rate your child's progress in the following subjects:

1- Below average

2- Average

3- Advanced

\_\_\_\_\_ Reading \_\_\_\_\_ Writing \_\_\_\_\_ Spelling \_\_\_\_\_ Arithmetic

Child's current reading level: Grade \_\_\_\_\_

Does your child like school? \_\_\_\_ yes \_\_\_\_no

Specifically describe any school difficulties

\_\_\_\_\_  
\_\_\_\_\_

Do you feel your child is reaching his/her potential? \_\_\_\_ yes \_\_\_\_no

Does the teacher feel your child is achieving his/her potential? \_\_\_\_ yes \_\_\_\_no

Does your child have an IEP at school? \_\_\_\_ If so, describe the type of accommodation?

\_\_\_\_\_

Does your child like to read? \_\_\_\_\_ yes \_\_\_\_\_ no

Voluntarily? \_\_\_\_\_ yes \_\_\_\_\_ no

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 on homework each day? \_\_\_\_\_

To what extent do you assist your child with homework? \_\_\_\_\_

**MEDICAL HISTORY**

Has there been a severe childhood illness, high fever, injury or physical impairment?

\_\_\_\_\_ yes \_\_\_\_\_ no If yes, explain \_\_\_\_\_

Are there any chronic problems like ear infections? Asthma, hay fever, allergies? \_\_\_\_\_

If yes, please list: \_\_\_\_\_

Has your child previously taken medication for hyperactivity \_\_\_\_\_ If yes, still on it? \_\_\_\_\_

Has your child received a hearing test? \_\_\_\_\_ yes \_\_\_\_\_ no

Has a hearing of speech deficiency been previously diagnosed? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, explain: \_\_\_\_\_

Has your child received any special testing with respect to a present learning problem?

\_\_\_\_\_  
\_\_\_\_\_

Has your child ever had any special tutoring or therapy?

\_\_\_\_\_  
\_\_\_\_\_

**LEISURE TIME ACTIVITIES**

How much time per day does your child spend watching TV? \_\_\_\_\_ Viewing distance? \_\_\_\_\_

How much time per day does your child spend on computer/video games? \_\_\_\_\_

What extracurricular activities does your child enjoy? \_\_\_\_\_

Are there any activities your child would like to participate in, but doesn't? \_\_\_\_\_ If so, please explain

\_\_\_\_\_