New England College of Optometry

CENTER FOR EYE CARE

CHILDREN'S VISION QUESTIONNAIRE

Please fill out this questionnaire and return it to the clinic prior to the evaluation.

Patient's Name: _____ Gender: _____
Birth Date: _____ Age: _____ years _____ months

RESPONSIBLE PERSON INFORMATION

Please note that payment is expected on the day of the evaluation (check or cash). A fee slip will be given that can be submitted for insurance reimbursement depending on the particulars of your health insurance plan.

Parent/Caretaker: _____ Birth Date: _____
Parent/Caretaker: _____ Birth Date: _____
Home Address: _____ City/State:_____ Zip: _____
Home Phone: _____ Cell Phone: _____
Email: _____
Parent/Caretaker's Occupation: _____ Business and/or cell Phone: _____
Business Address: _____ City/State: _____Zip: _____
Parent/Caretaker's Occupation: _____ Business and/or cell Phone: _____
Business Address: _____ City/State: _____Zip: _____

Please list the names and birth dates of your family:
Sibling: _____Birth Date: _____
Sibling: _____Birth Date: _____
Sibling: _____Birth Date: _____

Whom may we thank for this referral? _____
Address: _____ Phone: _____
Name and address of child's school: _____
Grade: _____ Child's dominant hand (circle): right or left?

PRESENT SITUATION

Why do you feel your child needs a visual evaluation? _____
_____
How long has this problem/difficulty been observed? _____
Is this problem/difficulty a result of a work-related accident? _____
Is there any evidence from the school, psychological, or other tests that indicates some visual malfunction may be present? Yes ☐ No ☐
If yes, what? _____
_____

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 problems:

Name/Relationship	Age	Visual Situation

Does **your child** report any of the following:	**Yes**	**No**	**If yes, when?**
Headaches	☐	☐	
Blurred vision/focus goes in and out	☐	☐	
Double vision	☐	☐	
Eyes hurt	☐	☐	
Eyes tired	☐	☐	
Words move around on the page	☐	☐	
Motion sickness/car sickness	☐	☐	
Dizziness	☐	☐	

List any other complaints your child makes concerning his/her vision: _____

Have **you or anyone else** ever noticed the following regarding your child:

	Yes	**No**	**If yes, when?**
Eyes frequently reddened	☐	☐	
Frequent eye rubbing	☐	☐	
Frequent sties	☐	☐	
Frowning	☐	☐	
Bothered by light	☐	☐	
Frequent blinking	☐	☐	
Closing or covering one eye	☐	☐	
Difficulty seeing distant objects	☐	☐	
Head close to paper when reading or writing	☐	☐	
Avoids reading	☐	☐	
Prefers being read to	☐	☐	
Tilts head when reading	☐	☐	
Tilts head when writing	☐	☐	
Moves head when reading	☐	☐	
Confuses letter or words	☐	☐	
Reverses letter or words	☐	☐	
Confuses right and left	☐	☐	
Skips, rereads or omits words	☐	☐	
Loses place while reading	☐	☐	
Vocalizes when reading silently	☐	☐	
Reads slowly	☐	☐	
Uses finger as a marker	☐	☐	

	Yes	No	If yes, when?
Poor reading comprehension	☐	☐	
Comprehension decreases over time	☐	☐	
Writes or prints poorly	☐	☐	
Writes neatly but slowly	☐	☐	
Does not support paper when writing	☐	☐	
Awkward or immature pencil grip	☐	☐	
Frequent erasures	☐	☐	
Tires easily	☐	☐	
Difficulty copying from chalkboard	☐	☐	
Difficulty recognizing same word on different page	☐	☐	
Poor word attack skills	☐	☐	
Difficulty with memory	☐	☐	
Remembers better what hears than sees	☐	☐	
Responds better orally than by writing	☐	☐	
Seems to know material, but does poorly on tests	☐	☐	
Dislikes/avoids near tasks	☐	☐	
Short attention span/loses interest	☐	☐	
Poor large motor coordination	☐	☐	
Poor fine motor coordination	☐	☐	
Difficulty with scissors/small hand tools	☐	☐	
Dislikes/avoids sports	☐	☐	
Difficulty catching/hitting a ball	☐	☐	

Please include copies of all the tests and evaluations that have been completed:

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 educational/ neuropsychological testing been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations: _____

Has an occupational therapy, physical therapy or speech/language evaluation been performed?
Yes ☐ No ☐ By whom? _____ Results and recommendations: _____

MEDICAL HISTORY

Pediatrician's Name: _____ Date of Last Evaluation: _____
Diagnoses and recommendations: _____

Medications currently using, including vitamins and supplements: _____

For what condition(s)? _____

Current diet restrictions and/or concerns: _____

Any reactions to immunization(s)? Yes ☐ No ☐ If yes, explain: _____

List illnesses, bad falls, high fevers, etc.:

Age Severe Mild Complications

_____

_____

_____

Has your child had any head traumas or accidents? Please describe: _____

_____

_____

Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes ☐ No ☐

If yes, please list: _____

Is there any known history of the following?

	Patient	Family	Who		Patient	Family	Who
Eyes	☐	☐	_____	Neurological	☐	☐	_____
Ears, Nose, Throat	☐	☐	_____	Endocrine Disorder	☐	☐	_____
Cardiovascular health	☐	☐	_____	Genitourinary	☐	☐	_____
Respiratory	☐	☐	_____	Skin	☐	☐	_____
Gastrointestinal health	☐	☐	_____	Musculoskeletal	☐	☐	_____
Psychiatric	☐	☐	_____	Hematological/lymphatic	☐	☐	_____
Allergic/immunologic	☐	☐	_____	Other	☐	☐	_____

	Patient	Family	Who		Patient	Family	Who
Diabetes	☐	☐	_____	High Blood Pressure	☐	☐	_____
"Cross" or "Wall" eye	☐	☐	_____	Learning Issues	☐	☐	_____
Chromosomal Imbalance	☐	☐	_____	Amblyopia (lazy eye)	☐	☐	_____
Thyroid Condition	☐	☐	_____	Multiple Sclerosis	☐	☐	_____
Glaucoma	☐	☐	_____	Epilepsy or Seizures	☐	☐	_____
Macular Degeneration	☐	☐	_____	Autism Spectrum Disorder	☐	☐	_____

If other, please explain: _____

_____

Any learning problems in the family? _____

DEVELOPMENTAL HISTORY

Adopted: Yes ☐ No ☐ Age when adopted _____ Country of origin_____

Does the child know that he/she was adopted? Yes ☐ No ☐

Full-term pregnancy? Yes ☐ No ☐

Did the birth mother experience any health problems during the pregnancy? Yes ☐ No ☐

If yes, explain: _____

Any complications before, during or immediately following delivery? Yes ☐ No ☐

If yes, explain: _____

Birth weight: _____ Apgar scores @ birth: _____ After 10 minutes: _____

Was there ever any 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 child active? Yes ☐ No ☐
Speech: First words: _____ At what age: _____
Was early speech clear to others? Yes ☐ No ☐
Is speech clear now? Yes ☐ No ☐

SCHOOL

Does your child like school? Yes ☐ No ☐
Specifically describe any school difficulties: _____
_____
Has your child changed schools often? Yes ☐ No ☐
If yes, when? _____
Has a grade been repeated? Yes ☐ No ☐
If yes, which and why? _____
Does your child seem to be under tension or extreme pressure when doing school work? Yes ☐ No ☐
Has your child had any special tutoring, therapy, and/or remedial assistance? Yes ☐ No ☐
If yes, when? _____
Where and from whom? _____
Does your child like to read? Yes ☐ No ☐
Voluntarily? Yes ☐ No ☐
Does your child read for pleasure? Yes ☐ No ☐ Type of book_____
What is your child's attitude toward reading, school, his/her teachers, other youngsters? _____
_____
Overall schoolwork is: above average ☐ average ☐ below average ☐

<u>Which subjects are</u>:

Above average: _____
Average: _____
Below average: _____
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 each day on homework assignments? _____
To what extent do you assist your child with homework? _____
Do you feel your child is achieving up to potential? Yes ☐ No ☐
Does the teacher feel your child is achieving up to potential? Yes ☐ No ☐

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 fatigue? sag ☐ irritable ☐ other ☐
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: _____
How does your child get along with:
Parents/other caretakers? _____ Siblings? _____
Classmates in school? _____ Playmates at home? _____

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: _____

TELEVISION/COMPUTER/TABLET/SMART PHONE VIEWING

Does your child watch TV? ___ How much? _____ How often? _____ Viewing distance? _____
Does your child spend time using computer/tablet/smart phone/video games? Yes ☐ No ☐
If yes, how much? _____ How often? _____ Viewing distance? _____
What activities does your child do on his/her/your smart phone? _____
Watch videos? ☐ Texting? ☐ Play games? ☐

IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL/IMPORTANT IN OUR TREATMENT OF YOUR CHILD?

_____
_____
_____
_____
_____

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation of your child and to better meet your child's specific visual needs. If you would like to communicate via email, please complete and sign the Authorization to Email Protected Health Information form located on the website. Please mail or fax the completed forms to:

NECO Center for Eye Care
930 Commonwealth Ave
Boston, MA 02215
Fax: 617-396-8517

Please be on time for your examination so that we will have the maximum opportunity to evaluate your child's visual status.

Sincerely,

Celia Hinrichs, O.D., FCOVD
Gayathri Srinivasan, OD, MS, FAAO