TEENAGE VISION QUESTIONNAIRE

Please fill out this questionnaire and return it to our office before the evaluation.

Patient's Name: ____ Gender: ____________
Birth Date: ________________________________ Age: ______ years ______ months

RESPONSIBLE PERSON INFORMATION

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	Age	Visual Situation

Have **you or anyone else** ever noticed the following:

	Yes	**No**	**If yes, when and who noticed?**
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	☐	☐	
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	☐	☐	
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	☐	☐	

	Yes	No	If yes, when and who noticed?
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 reports 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 an occupational therapy, physical therapy or speech/language evaluation been performed?
Yes ☐ No ☐ By whom? ________________ Results and recommendations: ________________
____
____

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

MEDICAL HISTORY

Pediatrician's Name: ________________ Date of Last Evaluation: ________________
Diagnoses and recommendations: ________________________________
Your current state of health: ________________________________
Medications currently using, including vitamins and supplements: ________________
____
For what condition(s)? ________________________________
____
Any reactions to immunization(s)? Yes ☐ No ☐ If yes, explain: ________________
____

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

Age	Severe	Mild	Complications

Have you had any head traumas or accidents? Please describe ______________________________

____

____

____

Are there any chronic problems like colds, asthma, hay fever, allergies? Yes ☐ No ☐
If yes, please list: ____

____

Current diet restrictions and/or concerns:____

____

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: ____

____

DEVELOPMENTAL HISTORY:
Adopted: Yes ☐ No ☐ age when adopted_____ country of origin______________
Does the teenager 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: ____
Was there ever any reason for concern over general growth or development?
Yes ☐ No ☐.
If yes, why? ____

TELEVISION/COMPUTER/TABLET/SMART PHONE VIEWING/LEISURE TIME ACTIVITIES
Do you watch TV? __________ How much? _______ How often? _______ Viewing distance? _______
Do you spend time using computer/tablet/smart phone/video games? Yes ☐ No ☐
If yes, how much? ____________ How often? ____________ Viewing distance? ____________________
What activities do you do on your smart phone? ____
Watch videos? ☐ Texting? ☐ Write papers? ☐
What other activities occupy your leisure time? ____

Are there any activities you would like to participate in, but don't? ___
Please explain: ____
____

SCHOOL
Do you like school? Yes ☐ No ☐
Specifically describe any school difficulties: ______________________________
____
Has a grade been repeated? Yes ☐ No ☐
If yes, which and why? ______________________________
Do you seem to be under tension or extreme pressure when doing school work? Yes ☐ No ☐

Have you had any special tutoring, therapy, and/or remedial assistance? Yes ☐ No ☐
If yes, when? ______________________________
Where and from whom? ______________________________
Do you like to read? Yes ☐ No ☐
Voluntarily? Yes ☐ No ☐
Do you read for pleasure? Yes ☐ No ☐
What? ______________________________

What is your attitude toward reading, school, your teachers, peers? ____________
____
Overall schoolwork is: above average ☐ average ☐ below average ☐
Which subjects are:
Above average: ______________________________
Average: ______________________________
Below average: ______________________________
Do you need to spend a lot of time/effort to maintain this level of performance?
Yes ☐ No ☐
How much time on average do you spend each day on homework assignments? __________
To what extent do you get assistance with homework? ______________________
Do you feel you are achieving up to your potential? Yes ☐ No ☐
Do you think your teachers feel you are achieving up to your potential? Yes ☐ No ☐
FAMILY AND HOME
Please indicate which adult(s) you live with? Mother ☐ Father ☐ Stepmother ☐
Stepfather ☐ Foster Parents ☐ Adoptive Parents ☐ Grandmother ☐ Grandfather ☐
Aunt ☐ Uncle ☐ Other Caretaker (please specify): ______________________
Do you spend time with any other person, not in the home? Yes ☐ No ☐
Please explain: ______________________________
How do you get along with:
Parents/other caretakers?________________Siblings? ______________________
Classmates in school?______________________________
Any learning problems in the family?..______________________________
____
Have you ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? Yes ☐ No ☐
If yes, at what age: ______________________
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: ______________________________

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

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____

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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. Completed questionnaires can be mailed or faxed to:

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

If you have any questions on concerns that we may answer prior to your appointment, please do not hesitate to contact us.

You may leave a message for us 24 hours a day /7 days a week. We request a minimum of 24 hours notice if you are unable to keep this appointment.

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

Thank you,

Celia Hinrichs, O.D., F.C.O.V.D.
Gayathri Srinivasan, OD, MS, FAAO