New England College of Optometry

CENTER FOR EYE CARE

TODDLER/PRESCHOOL VISION QUESTIONNAIRE

Please fill out this questionnaire and send it to the clinic prior to your appointment.

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 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 and the reason:

Name / Relationship	Age	Visual Situation

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

	Yes	No	If yes, when?
An eye turns in or out	☐	☐	
Reddened or encrusted eyelids	☐	☐	
Frequent sties	☐	☐	
Eyes in constant motion	☐	☐	
Eyelids droop	☐	☐	
Stares at bright lights or repeatedly flicks objects in front of face	☐	☐	
Is abnormally bothered by bright light	☐	☐	
Seems visually unaware	☐	☐	
Has watery eyes	☐	☐	
Turns head to use one eye only	☐	☐	
Tilts head to one side	☐	☐	
Moves objects very close to look at them	☐	☐	
Squints while looking at objects	☐	☐	
Blinks excessively	☐	☐	
Has a tendency to rub eyes	☐	☐	
Covers or closes one eye	☐	☐	
Stumbles over objects or is clumsy	☐	☐	
Poor motor control	☐	☐	
Lacks interest in looking at objects or seeing	☐	☐	
Unable to see distant objects	☐	☐	
Unable to transfer object from hand to hand, or crossing the midline of the body	☐	☐	
Is unable to stack blocks or other objects	☐	☐	

Does **your child** verbalize any problems/complaints about his/her eyes or vision? Yes ☐ No ☐
If yes, explain: _____

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)? _____

_____

Immunizations child has received and dates:

Immunization type: _____ Date: _____
Immunization type: _____ Date: _____
Immunization type: _____ Date: _____

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

_____

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

Age Severe Mild Complications

_____

_____

_____

Is your child generally healthy? Yes ☐ No ☐

If no, explain: _____

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

If yes, please list: _____

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

_____

_____

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 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: _____
Were there any difficulties at all in feeding (such as difficulty with sucking, vomiting?) Yes ☐ No ☐
If yes, explain: _____
Any problems with colic? Yes ☐ No ☐
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 ☐
How many hours daily does your child sleep? _____
Does your child sleep through the night? Yes ☐ No ☐ If yes, starting at what age: _____
If no, explain: _____
What percent of the waking hours is/was your child in a playpen? _____
In a walker? _____
In a seat? _____
What things can your child do very well? _____

_____
What things, if any, are difficult for your child? _____

_____
Was there ever any reason for concern over your child's general growth or development?
Yes ☐ No ☐
If yes, why? _____
Has your child received any special developmental guidance/assistance? Yes ☐ No ☐
If yes, explain: _____

NUTRITIONAL INFORMATION

Are there any food allergies/sensitivities? Yes ☐ No ☐
If yes, what: _____
Was your child nursed? ☐ Until what age: _____ Bottle fed? ☐ Until what age? _____
Solid food started at what age: _____ What type? _____
Activity Level: High ☐ Moderate ☐ Low ☐
Are there periods of very <u>high</u> energy Yes ☐ No ☐
Are there periods of very <u>low</u> energy? Yes ☐ No ☐
Does your child: Like sweets ☐ and/or Crave sweets ☐
If so, what? _____

What are his/her favorite foods? _____
What foods does he/she dislike/avoid? _____

PRE-SCHOOL

******If your child attends preschool, please fill out the following:
Name of Pre-school: _____ Teacher: _____ Director: _____
Age at time of entrance to pre-school: _____
Does your child like pre-school? Yes ☐ No ☐
Does your child like teacher? Yes ☐ No ☐
Compared to other children his/her age, do his/her general performance and social skills seem to be:
above ☐ equal to ☐ or below ☐
Please explain: _____
Which pre-school activities are easy for your child? _____

_____

Which pre- school activities are difficult for your child? _____

_____

Specifically describe any pre-school / day care concerns / difficulties: _____

_____

_____

Does your child seem to be under tension at pre-school/day care? Yes ☐ No ☐
If yes, 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? ☐ Play games? ☐

CURRENT ABILITIES/BEHAVIOR

Where appropriate, list the age at which your child could do the following: (some of these behaviors may not apply due to your child's chronological age).

	Age		Age
Responsive smile	_____	Stack blocks	_____
Crawl (stomach on floor)	_____	Walk alone	_____
Roll over	_____	Scribble spontaneously	_____
Creep (stomach of floor)	_____	Kick a ball	_____
Sit up alone	_____	Walk up steps with help	_____
Respond to words and names	_____	Use two-word sentences	_____
Say single words	_____	Become toilet-trained	_____
Give first name	_____	Put on some clothing alone	_____

Can your child identify colors? Yes ☐ No ☐ If yes, which? _____
Can your child identify numbers or letters? Yes ☐ No ☐ If yes, which? _____
Does your child like to draw/color? Yes ☐ No ☐

Is your child learning to read? Yes ☐ No ☐
How is your child performing as compared to others his/her age:
Above average ☐ Below average ☐
How well developed is your child's spoken vocabulary? _____
How well does your child understand/respond to spoken language? _____

Check the appropriate spaces if you have any concerns about the following behavior(s) in your child:

Lack of curiosity	☐	Irritable, easily upset	☐
Thumb-sucking	☐	Restlessness	☐
Nervous	☐	Has difficulty separating from parents	☐
Glum, sulky, moody	☐	Sleeplessness	☐
Temper concerns	☐	Lethargic, low energy	☐
Passive	☐	Aggressive	☐

Other (please explain): _____

_____

_____

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: _____

<u>GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON</u>:

_____

_____

_____

_____

_____

_____

_____

Is there any other information that would be helpful/important in our evaluation or 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 enclosed 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 or concerns that we may answer prior to your appointment, please do not hesitate to contact us.

Sincerely,

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