PRE-EXAMINATION QUESTIONNAIRE (CHILD)

Welcome to our practice!

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

Address:	**Person Responsible for Account:** *parent / other*
City / State / Zip:	Name:
Home Phone: ( ) -	Method of Payment: (circle)
Child Social Security #	Cash / Check / VISA / MC / Discover
School:	Vision Insurance:
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 above line 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			
4			

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

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

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

HEALTH & MEDICAL CONDITIONS

Circle Appropriate Answer **Explain if additional information is necessary**

Yes	No	Has your child ever worn glasses?	
Yes	No	Has your child ever had any eye injuries or accidents?	
Yes	No	Has your child ever undergone eye surgery?	
Yes	No	Has your child ever worn an eye patch?	
Yes	No	Has your child been diagnosed with lazy eye or strabismus?	
Yes	No	Has your child had any form of vision therapy?	
Yes	No	Was your child born more than 30 days premature?	
Yes	No	Were there any significant complications before or after delivery?	
Yes	No	Do any relatives have any serious eye problems?	

In the space below please list any medical conditions and medications. Be sure to include developmental, neurological, and psychological conditions. Also list any other issues that may be pertinent to today's exam.

Does your child have any allergies (list)? ____________________

Is your child's schoolwork (circle one):	Satisfactory		Below Expectations		Very Good	
Does your child have problems in any subjects?	Reading	Math	Spelling	Writing	History	Science

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

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

List any activities that your child is involved in that have specific visual needs or risks. Include hobbies, interests, sports, etc. . .

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 of 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 was read or what he or she was told
_____ 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 prescription sunglasses?	Yes	No

When you visit our practice you may be interested to know what we will do to ensure you clear, comfortable vision. First and foremost, we will perform a thorough examination of your eye health. We are sure you will recognize the importance of this. Second, we conduct a binocular vision screening to determine how well your eyes work together as a team. We then carefully examine your eyes to determine what lens correction, if any, is necessary to give you clear, comfortable and efficient vision . . . the vision you require for all the things you do.

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 ________