CHILD HISTORY QUESTIONNAIRE

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Child's Full Name________________________________ Nickname____________________
Today's Date________________ Birthdate________________ Age Now________________
Parent's Name(s)____
School____ Grade_______________
Teacher's Name____

A. Present Situation

1. Why do you feel your child needs a visual examination? _________________________________
   ____
2. Does your child complain of his/her vision? ______________________________________
3. Who first noted the visual difficulties? __________________ When? ________________
4. Did this difficulty occur suddenly? ________ Did it seem related to illness, accident, or any other related occurrence? ____
5. Request for evaluation initiated by: ____

Name___________________________________ Position ______________________
Address _________________________________ Phone ________________________

6. Have you noticed anything in home behavior to suggest difficulties? _____________________

Describe briefly: ____

7. Are glasses being worn? Yes_______ No_______ How long? ___________________________

Why were glasses prescribed: (Check reason)
Distant Vision: Blur_______ Headaches_______ Eye Turned_______
Near Vision: Comfort_______ Blur_______ Double_______ Not Known_______
Other reasons: ____
How often have changes been made? ____
When were present glasses prescribed? ____
Are they comfortable? Yes_______ No_______ Explain_____________________________

8. Has your child ever participated in a visual training program? ________________________
9. Has your child ever had any operations on his/her eyes? Yes_______ No_______

Explain____

10. Have "drops" ever been used in the examination of your child? _______________________

What were the reactions or effects of the "drops" that you could observe? __________________
____

11. Does your child report any of the following, and if so, when?

	YES	NO	WHEN
A. Headaches	______	______	________________
B. Blurred Vision Far Away	______	______	________________
C. Blurred Vision Up Close (Reading)	______	______	________________
D. Double Vision	______	______	________________
E. Eyes "Hurt" or "Tired"	______	______	________________
F. Nausea or Dizziness	______	______	________________
G. Car Sickness	______	______	________________
H. Bothered By Light	______	______	________________
I. Spots Before the Eyes	______	______	________________

OVER ➡

12. Have you or anyone else ever noted the following, and if so, when?

	YES	NO	WHEN
A. One eye turn in or out at any time	______	______	__________________
B. Reddened eyes or lids	______	______	__________________
C. Eyes tear excessively	______	______	__________________
D. Encrusted eyelids	______	______	__________________
E. Frequent styes on lids	______	______	__________________
F. Excessive eye rubbing	______	______	__________________
G. Excessive blinking	______	______	__________________
H. Holding reading close	______	______	__________________
I. Closing one eye frequently	______	______	__________________
J. Covering one eye frequently	______	______	__________________
K. Tilting head when reading	______	______	__________________
L. Inability to see distant objects	______	______	__________________
M. Squinting	______	______	__________________
N. Bumping into objects	______	______	__________________
O. Poor general coordination	______	______	__________________
P. Head turns as reads across the page	______	______	__________________
Q. Loses place when reading	______	______	__________________
R. Needs finger or marker to keep place	______	______	__________________
S. Repeats or omits words or lines while reading	______	______	__________________
T. Confuses left-right directions	______	______	__________________
U. Reverses words, letters, or numbers while reading	______	______	__________________
V. Short attention span while reading	______	______	__________________
W. Fatigues easily	______	______	__________________
X. Poor posture	______	______	__________________
Y. Writes crookedly, poorly spaced: Cannot stay on ruled lines	______	______	__________________
Z. Comprehension reduces as reading Continued; loses interest too quickly	______	______	__________________
AA. Difficulty copying from chalkboard	______	______	__________________
BB. Difficulty with spelling	______	______	__________________

B. GENERAL HEALTH

1. Illness and age at time of each
   a. ____________________________ Age______________ Severity_____________________
   b. ____________________________ Age______________ Severity_____________________
   c. ____________________________ Age______________ Severity_____________________

   Comments: ____
2. Allergies (frequency and treatment)? ____

   ____
3. Is your child presently under a physician's care? ___________________ Purpose? ___________
   Is s(he) receiving any medication at present? _____________ Purpose? ____________________
4. Does your child become feverish easily? __________ When? _____________________________
   Is it high fever? ___________ What and when was the highest fever? ______________________
5. Has s(he) ever had any injuries involving the eyes, head, neck, or spine? Yes ______No ______

C. GENERAL BEHAVIOR

1. Which hand does your child prefer to use? ____
   Was hand preference ever changed? Yes_________ No__________ Explain________________
2. What are your child's special interests/hobbies? ____
3. Is play very active or very quiet? ____
4. Is your child good with hands (for present age)? ____
5. Do erector sets, cutting, coloring, and puzzles hold attention? ___________________________
6. Can s(he) throw and catch a ball?) ____
7. Does your child get along with adults? _______________ Other children? __________________
8. Is your child observant? ____________________ Is your child distractible? ________________
9. Does your child like books and magazines? ________ Does s(he) like to be read to? __________
   When do you do the most reading to you child: Nap time, bed time, or other? _______________
10. Give a brief thumbnail sketch of your child's personality:_________________________________

D. School History

1. At what age did your child enter first grade? Years _______________ Months ______________
   How long in Kindergarten? ____________________ Nursery School? ______________________
2. Does s(he) attend school regularly or has s(he) had frequent absences? ______________________
3. Has s(he) changed schools frequently? Yes______ No _________
   When and Why? ____
4. How is the child getting along in school? ____
   What is his/her favorite subjects? ____
   Which subjects present difficulties? ____
   When was difficulty first noted? ____
5. Has s(he) ever repeated a grade? _______________ Why? _____________________________
6. What is your child's attitude toward school, reading, teachers, and other youngsters? _________
   ____
7. Has s(he) had any special tutoring and remedial work? Yes______ No _________
   When and from whom? ____
8. Has the teacher reported anything about your child's school work? Yes______ No _________
   If so, what? ____

E. DEVELOPMENTAL HISTORY

Source of data: Baby book________ Other records________ Memory________

1. Birth data: Normal_______ Premature_______ Overdue_______
   Instrument Delivery_______ Caesarian Section_______ Injury_______
   Complications______________________________ Weight____________
2. Was your child active in crib? _______________ Since? _________________________
3. Was your child an "easy" or a "difficult" baby? ______________ (Good or fussy)
   Any colic or early management problems? ________________________________
4. Did s(he) have a play pen? __________ How often used? __________
   Did s(he) have a walker? __________ How often used? ___________
5. Was movement ever restricted by a cast or brace? _____________

OVER ➡

PERFORMANCE	AVERAGE	DATA	REMARKS
I. Location			
A. Sits momentarily	6-8 months		
B. Crawl	7-9 months		
C. Stand alone	12-15 months		
D. Walk alone	12-15 months		
II. Elimination			
A. Established bowel control	12-24 months		
B. Established bladder control	2-3 years		
III. Dressing			
A. Buttons clothes	4 years		
B. Laces shoes	5 years		
IV. Speech			
A. Sounds			
1. Syllables	6 months		
2. Da-da, etc.	9 months		
B. Words			
2 words	12 months		
4 words `	15 months		
C. Sentences			
Short sentences	24 months		
Gives full name	30 months		

Check one reason for this appointment:
Standard vision and eye health exam______ Exam for underachieving child______
Who will be the responsible party for payment? ____________________________
Method of payment preferred: CASH CHECK CREDIT CARD

As you complete this history questionnaire you will recognize the thoroughness with which your child's vision will be considered. The office examination will take up enough time to permit a very complete optometric investigation of the problem. Your child's future deserves the fullest consideration that you, as parents, and Snowy Range Vision Center can provide. If you will consent to our sending a similar questionnaire to your child's teacher and also sending him or her a report of your child's visual status so that s(he) may better understand your child's visual needs as they relate to the classroom, please sign below.

Signature of parent/guardian___________________________________ Date_______________