Snowy Range Vision Center

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Child History Questionnaire

Child's Full Name: _____ Nickname: _____
Today's Date: _____ Birthdate: _____ Age now: _____
Parent's Name(s): _____
School: _____ Grade: _____
Teacher's name: _____

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.

Present Situation

1. Why do you feel your child needs a visual examination? _____
   _____
2. Does your child complain of his/her vision? ☐ No ☐ Yes: _____
3. Who first noted the visual difficulties? _____ When? _____
4. Did this difficulty occur suddenly? ☐ No ☐ Yes Did it seem related to an illness, accident, or any other related occurrence? ☐ No ☐ Yes: _____
5. Request for evaluation initiated by: Name: _____
   Position/relationship: _____
6. Have you noticed anything in home regarding behavior to suggest difficulties? ☐ No ☐ Yes
   Describe: _____
7. Are glasses being worn? ☐ No ☐ Yes, how long? _____
   Why were glasses prescribed? ☐ Blurred vision (☐distance/ ☐near) ☐ Headaches ☐ Eye turn
   ☐ Double vision (☐ distance/ ☐ near) ☐ Comfort for near vision
   ☐ Unknown ☐Other: _____
   How often have changes been made in the prescription? _____
   When were the current glasses prescribed? _____
   Are they comfortable? ☐ No ☐ Yes Explain: _____
8. Has your child ever participated in a visual training program? ☐ No ☐ Yes: when? _____
9. Has your child ever had any operations on his/her eyes? ☐ No ☐ Yes: _____
10. Have eye drops ever been used in the examination of your child? ☐ No ☐ Yes
    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?

Complaint	Yes	No	When
Headaches	☐	☐	
Blurred vision far away	☐	☐	
Blurred vision up close/reading	☐	☐	
Double vision	☐	☐	
Eyes “hurt” or are “tired”	☐	☐	
Nausea or dizziness	☐	☐	
Car sickness	☐	☐	
Bothered by light	☐	☐	
Spots before eyes	☐	☐	

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

Concern	Yes	No	When
One eye turns in or out	☐	☐	
Reddened eyes or lids	☐	☐	
Eyes tear excessively	☐	☐	
Encrusted lids	☐	☐	
Frequent styes on lids	☐	☐	
Excessive eye rubbing	☐	☐	
Excessive blinking	☐	☐	
Holding reading very close	☐	☐	
Closing one eye frequently	☐	☐	
Covering one eye frequently	☐	☐	
Tilting head when reading	☐	☐	
Squinting	☐	☐	
Bumping into objects	☐	☐	
Poor general coordination	☐	☐	
Head turns when reading across page	☐	☐	
Loses place when reading	☐	☐	
Needs finger or marker to keep place	☐	☐	
Repeats or omits words or lines	☐	☐	
Confuses left and right directions	☐	☐	
Reverses words, letters, or numbers	☐	☐	
Short attention span while reading	☐	☐	
Fatigues easily	☐	☐	
Poor posture	☐	☐	
Writes crookedly; poorly spaced	☐	☐	
Reduced reading comprehension	☐	☐	
Difficulty copying from the board	☐	☐	
Difficulty with spelling	☐	☐	

General Health

1. Please list any illnesses and the age of your child at the time:

Illness	Age	Severity

2. Does your child have any allergies? ☐ No ☐ Yes: _____
   How frequent do they occur? _____
   Is your he/she receiving any treatment for them? ☐ No ☐ Yes: _____
3. Is your child presently under a physician's care? ☐ No ☐ Yes: for: _____
4. Is he/she receiving any medication at present? ☐ No ☐ Yes: for: _____
5. Does your child become feverish easily? ☐ No ☐ Yes: when? _____
   Is it often a high fever? ☐ No ☐ Yes
   When was the highest fever, and what was the cause? _____
6. Has he/she ever had any injuries involving the eyes, head, neck, or spine? ☐ No ☐ Yes:
   When?: _____ Please describe: _____

General Behavior

1. Which hand does your child prefer to use? ☐ Right ☐ Left
   Has hand preference ever changed? ☐ No ☐ Yes: 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)? ☐ No ☐ Yes
5. Do erector sets, cutting, coloring, and puzzles hold attention? ☐ No ☐ Yes
6. Can he/she throw and catch a ball? ☐ No ☐ Yes
7. Does your child get along with adults? ☐ No ☐ Yes Other children? ☐ No ☐ Yes
8. Is your child observant? ☐ No ☐ Yes
9. Is your child distractible? ☐ No ☐ Yes
10. Does your child like books and magazines? ☐ No ☐ Yes
11. Does he/she like to be read to? ☐ No ☐ Yes
12. When do you do the most reading to your child: ☐ nap time ☐ bed time ☐ other: _____
13. Give a brief thumbnail sketch of your child's personality: _____

School History

1. At what age did your child enter and leave the following?
   a. Nursey school entered _____, left _____
   b. Kindergarten entered _____, left _____
   c. First grade entered _____, left _____
2. Does he/she attend school regularly or have they had frequent absences? _____
3. Has he/she changed schools frequently? ☐ No ☐ Yes: when/why: _____
4. How is the child getting along in school? _____
5. What is their favorite subjects? _____
6. Which subjects present difficulties? _____

7. When was difficulty first noted? _____
8. Has he/she ever repeated a grade? ☐ No ☐ Yes: why? _____
9. What is your child's attitude toward school, reading, teachers, and other children? _____

   _____
10. Has he/she had any special tutoring or remedial work? ☐ No ☐ Yes
    If so, when and for what? _____
11. Has the teacher reported anything about your child's school work? ☐ No ☐ Yes
    If so, what? _____

Developmental History

1. Source of data ☐ Baby book ☐ Other records ☐ Memory
2. Birth data: ☐ Normal ☐ Premature ☐ Overdue ☐ Weight _____
   ☐ Instrument Delivery ☐ C – Section ☐ Injury
   ☐ Complications: _____
3. Was your child active in crib? ☐ No ☐ Yes, since: _____
4. Was your child an "easy" or a "difficult" baby (good or fussy)? _____
   Any colic or early management problems? ☐ No ☐ Yes: _____
5. Did he/she have a play-pen? ☐ No ☐ Yes: How often used? _____
   Did he/she have a walker? ☐ No ☐ Yes: How often used? _____
6. Was movement ever restricted by a cast or brace? ☐ No ☐ Yes: explain: _____
7. Indicate when your child reached the following developmental stages:

Performance type	Activity	Avg. Age	Early	Late	Normal	Unsure
Location	Sits momentarily	6-8 months	☐	☐	☐	☐
	Crawls	7-9 months	☐	☐	☐	☐
	Stands alone	12-15 months	☐	☐	☐	☐
	Walks alone	12-15 months	☐	☐	☐	☐
Elimination	Bowel control	12-24 months	☐	☐	☐	☐
	Bladder control	2-3 years	☐	☐	☐	☐
Dressing	Buttons clothes	4 years	☐	☐	☐	☐
	Laces shoes	5 years	☐	☐	☐	☐
Speech	Sounds: Syllables	6 months	☐	☐	☐	☐
	Sounds: Da-da, etc.	9 months	☐	☐	☐	☐
	Words: two words	12 months	☐	☐	☐	☐
	Words: four words	15 months	☐	☐	☐	☐
	Sentences: short sentences	24 months	☐	☐	☐	☐
	Sentences: gives full name	30 months	☐	☐	☐	☐

If you will consent to our sending a similar questionnaire to your child's teacher and sending him or her a report of your child's visual status so that they may better understand your child's visual needs as they relate to the classroom, please sign below.

Signature of parent/guardian: _____ Date: _____