EyeCare™ Specialties
Center for Vision Development

2917 Pine Lake Road Suite B | Lincoln, NE 68512
402.420.2020 | eyecarespecialties.com

Extended Child Vision Questionnaire

Please fill this questionnaire out carefully and completely.

Appointment Date: _____

Optometrist: ☐ Rachel Smith, O.D., FCOVD ☐ Mikaela Betka, O.D.

General Information

Patient Full Name: _____

☐ Male ☐ Female Birth Date: _____ Age: _____

Name of School: _____ Grade: _____

Were you referred to our office? ☐ Yes ☐ No

If yes, whom may we thank for this referral? Name: _____

Is your child especially afraid of doctors? _____

Family Information

Please list the names of your family:

Father/Guardian: _____

Mother/Guardian: _____

Sibling: _____

Sibling: _____

Sibling: _____

Sibling: _____

Responsible Party Information

Name of responsible party: _____

Relationship to patient: ☐ Mother ☐ Father ☐ Guardian

Father's Employer: _____ Best Contact Phone: _____

Mother's Employer: _____ Best Contact Phone: _____

Guardian's Employer: _____ Best Contact Phone: _____

Medical History

Pediatrician's Name: _____ Date of last evaluation: _____

What prompted the last visit to the doctor? _____

Is your child under ongoing care for any medical conditions? _____

_____

Medications currently using, including vitamins and supplements: _____

_____

Has a neurological evaluation ever been performed? ☐ Yes ☐ No

By whom? _____ Results & Recommendations: _____

_____

Is there any history of the following?

Diabetes	☐ Patient	☐ Family	Relationship _____
High Blood Pressure	☐ Patient	☐ Family	Relationship _____
Multiple Sclerosis	☐ Patient	☐ Family	Relationship _____
Epilepsy	☐ Patient	☐ Family	Relationship _____
Learning Disability	☐ Patient	☐ Family	Relationship _____
High Fevers	☐ Patient		
Ear Infections	☐ Patient		
Bad Fall and/or Concussion	☐ Patient		

Developmental History

Full-term pregnancy? ☐ Yes ☐ No

Did the mother experience any health problems during pregnancy? ☐ Yes ☐ No

If yes, explain:_____

Normal birth? ☐ Yes ☐ No Were forceps used? ☐ Yes ☐ No

Any complications before, during or immediately following delivery? ☐ Yes ☐ No

If yes, explain:_____

Birth weight:_____lbs _____oz

Was there ever any reason for concern over your child's general growth or development? ☐ Yes ☐ No

If yes, why?_____

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 your child active? ☐ Yes ☐ No

Speech: First words:_____ At what age?_____

Was early speech clear to others? ☐ Yes ☐ No

Is speech clear now? ☐ Yes ☐ No

Has a speech therapy evaluation ever been performed? ☐ Yes ☐ No

If yes, by whom?_____

Has physical therapy ever been performed? ☐ Yes ☐ No

Has an occupational therapy evaluation ever been performed? ☐ Yes ☐ No

By whom?_____Results & Recommendations:_____

Visual History

Has your child's vision been previously evaluated? ☐ Yes ☐ No

If so, Doctor's name:_____Date of last evaluation:_____

Visual History (continued)

Reason for examination: _____

Results & Recommendations: _____

Were glasses, contact lenses, or other optical devices prescribed or recommended? ☐ Yes ☐ No

If yes, what? _____ Are they used? ☐ Yes ☐ No

If yes, when? _____ If not used, why? _____

Is there any history of the following?

Crossed or Wall Eye	☐ Patient	☐ Family	Relationship _____
Amblyopia/Lazy Eye	☐ Patient	☐ Family	Relationship _____
Glaucoma	☐ Patient	☐ Family	Relationship _____
Other (Please explain below)	☐ Patient	☐ Family	Relationship _____

Does your child report the following, or has anyone noticed the following:

Blur at distance	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Blur at near	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Headaches with near work	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Words run together or move on the page when reading	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Burning or watery eyes	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Eyes hurt/ache/fatigue with near work	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Falls asleep when reading	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Sees worse at the end of the day	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Skips/repeats lines	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Dizzy/nausea with near work	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Head tilt/closes one eye when reading	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Difficulty copying from board	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Avoids near work/reading	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Writes up/down hill	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Misaligns digits/columns of numbers	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always

Visual History (continued)

Does your child report the following, or has anyone noticed the following:

Reading comprehension down	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Poor/inconsistent in sports	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Holds reading too close	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Trouble keeping attention on reading	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Easily frustrated with near work/reading	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Poor eye/hand coordination (poor handwriting)	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Does not judge distance accurately	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Clumsy/knocks things over	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Car/motion sickness	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Forgetful/poor memory	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Eye turn	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Confuses left/right	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Confuses/reverses numbers, letters, or words	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Remembers better what he/she hears	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Prefers to be read to than to read him/herself	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Difficulty spacing between words when writing	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always

School

Age at time of entrance to: Preschool_____Kindergarten_____

Does your child like school? ☐ Yes ☐ No Below, describe in detail any school difficulties:_____

_____

_____

Has a grade been repeated? ☐ Yes ☐ No If yes, when & why?_____

_____

School (continued)

Does your child seem to be under tension or extreme pressure when doing schoolwork? ☐ Yes ☐ No

Has your child had any special tutoring, therapy, and/or remedial assistance? ☐ Yes ☐ No

If yes, when?_____

Where and from whom?_____

How long?_____Results:_____

Does your child like to read? ☐ Yes ☐ No

Does your child read for pleasure? ☐ Yes ☐ No

What is your child's attitude towards reading, school, his/her teachers?_____

_____

What subjects are:

Above Average_____

Average_____

Below Average_____

Does your child need to spend a lot of time/effort to maintain this level of performance? ☐ Yes ☐ No

How much time on average does your child spend each day on homework assignments?_____

To what extent do you assist your child with homework?_____

Do you feel your child is achieving up to potential? ☐ Yes ☐ No

Are there any behavior problems at school? ☐ Yes ☐ No

If yes, what?_____

What causes these problems?_____

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):_____

Are there any behavior problems at home? ☐ Yes ☐ No

If yes, what?_____

What causes these problems?_____

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 ongoing? ☐ Yes ☐ No

If no, please explain:_____

Is family life stable at this time? ☐ Yes ☐ No If no, please explain: _____

_____

How does your child get along with:

Parents/other caretakers:_____

Siblings: _____

Playmates:_____

Give a brief description of your child as a person:_____

_____

_____

_____

_____

Is there any other information you feel would be helpful or important in our treatment of your child?

_____

_____

_____

_____

Release of Information

It is often beneficial to us to discuss examination results and to exchange information with your child's school and/or other professionals involved in his/her care. Please sign below to authorize this exchange of information.

I agree to permit information from, or copies of, my child's examination records to be forwarded to my child's school or other healthcare providers listed on the back of this release form or upon the recommendation of EyeCare Specialties, P.C. when it is necessary for the treatment of my child's visual condition. I authorize Dr. Smith, Dr. Betka, and EyeCare Specialties, P.C. to exchange information with my child's school and other professionals involved in my child's care, by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

_____

Signature Date

_____

Relationship to patient

I hereby give my permission to EyeCare Specialties, P.C. to treat _____

Child's name

_____

Parent or Guardian Signature Date

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 have any questions or concerns that we may answer prior to your child's appointment, please do not hesitate to contact us at 402-323-2062. You may leave a message for us after the clinic hours and on weekends. We will return your call as soon as possible the next business day. We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your child's examination, so that we will have the maximum opportunity to evaluate your child's visual status. Thank you.

Sincerely,

Rachel M. Smith, OD, FCOVD

Developmental Optometrist

EyeCare Specialties, P.C. is authorized to exchange and/or share information regarding the treatment of my child's visual condition to the following school and health care professionals:

Name:____

School or Business:________________________________

Address:_______________________________________

City:__________________ State:__________ Zip:____________

Name:____

School or Business:________________________________

Address:_______________________________________

City:__________________ State:__________ Zip:____________

Name:____

School or Business:________________________________

Address:_______________________________________

City:__________________ State:__________ Zip:____________

Name:____

School or Business:________________________________

Address:_______________________________________

City:__________________ State:__________ Zip:____________

Name:____

School or Business:________________________________

Address:_______________________________________

City:__________________ State:__________ Zip:____________

Name:____

School or Business:________________________________

Address:_______________________________________

City:__________________ State:__________ Zip:____________