



**Eye Priority, P.C.**  
Dr. Kelly de Simone, F.C.O.V.D.  
15725 South 46<sup>th</sup> Street ♦ Suite 112 ♦ Phoenix ♦ AZ ♦ 85048  
480-893-2300 ♦ Fax 480-893-0522

**CHILDREN'S VISION QUESTIONNAIRE**

*Thank you for carefully completing the questionnaire. Please bring it to our office at your appointment time.*

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_  
Who may we thank for referring you to our office? \_\_\_\_\_ Sex: Male Female  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone Number \_\_\_\_\_ Email \_\_\_\_\_  
Preferred Method of Contact: Father's Cell Mother's Cell Home Email  
Father/Guardian Name \_\_\_\_\_ DOB \_\_\_\_\_  
Occupation \_\_\_\_\_ Cell phone \_\_\_\_\_  
Mother/Guardian Name \_\_\_\_\_ DOB \_\_\_\_\_  
Occupation \_\_\_\_\_ Cell phone \_\_\_\_\_  
Siblings' names and ages \_\_\_\_\_

Name of school attending \_\_\_\_\_ Present Grade \_\_\_\_\_  
Teacher's Name \_\_\_\_\_ School phone number \_\_\_\_\_

**Responsible Party and Insurance Information**

Person responsible for this account \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Do you have Major Medical Insurance? Yes No  
Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Insured's DOB \_\_\_\_\_  
Insured's SSN \_\_\_\_\_ Insured's Employer \_\_\_\_\_

I authorize the release of my medical and/or other information pertaining to my child's care at Eye Priority.

Print Name \_\_\_\_\_  
Signature \_\_\_\_\_ Relationship to patient \_\_\_\_\_

**Visual History**

What is the reason for today's visit? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did these symptoms first begin? \_\_\_\_\_  
Has the problem become better or worse? Please explain \_\_\_\_\_  
\_\_\_\_\_

Have you had a previous vision evaluation?    Yes    No  
 If yes, doctor's name \_\_\_\_\_ Date of evaluation \_\_\_\_\_

Were glasses, contact lenses or other optical devices recommended?    Yes    No  
 If yes, what \_\_\_\_\_ Date of evaluation \_\_\_\_\_  
 Are they used?    Yes    No    If yes, when? \_\_\_\_\_  
 If no, why not? \_\_\_\_\_

Were any additional tests, treatments or therapies recommended concerning your child's vision?    Yes    No  
 If yes, what? \_\_\_\_\_  
 Did your child undergo these treatments?    Yes    No    Explain \_\_\_\_\_  
 Results and recommendations \_\_\_\_\_

**Visual Symptom Checklist**

- |   |   |
|---|---|
| <input type="checkbox"/> Headaches                                | <input type="checkbox"/> Vocalizes when reading silently                    |
| <input type="checkbox"/> Blurred vision/focus goes in and out     | <input type="checkbox"/> Reads slowly                                       |
| <input type="checkbox"/> Double vision                            | <input type="checkbox"/> Uses finger as a marker                            |
| <input type="checkbox"/> Eyes hurt                                | <input type="checkbox"/> Poor reading comprehension                         |
| <input type="checkbox"/> Eyes tired                               | <input type="checkbox"/> Comprehension decreases over time                  |
| <input type="checkbox"/> Words move around on the page            | <input type="checkbox"/> Writes or prints poorly                            |
| <input type="checkbox"/> Motion sickness/car sickness             | <input type="checkbox"/> Writes neatly but slowly                           |
| <input type="checkbox"/> Dizziness                                | <input type="checkbox"/> Does not support paper when writing                |
| <input type="checkbox"/> Redness of the eyes                      | <input type="checkbox"/> Awkward or immature pencil grip                    |
| <input type="checkbox"/> Eyes frequently reddened                 | <input type="checkbox"/> Frequent erasures                                  |
| <input type="checkbox"/> Frequent eye rubbing                     | <input type="checkbox"/> Tires easily                                       |
| <input type="checkbox"/> Frequent sties                           | <input type="checkbox"/> Difficulty copying from chalkboard                 |
| <input type="checkbox"/> Frowning                                 | <input type="checkbox"/> Poor word attack skills                            |
| <input type="checkbox"/> Frequent blinking                        | <input type="checkbox"/> Difficulty with memory                             |
| <input type="checkbox"/> Closing or covering one eye              | <input type="checkbox"/> Remembers better orally than by writing            |
| <input type="checkbox"/> Difficulty seeing distant objects        | <input type="checkbox"/> Knows material, but does poorly on tests           |
| <input type="checkbox"/> Head close to paper when reading/writing | <input type="checkbox"/> Dislikes/avoids near tasks                         |
| <input type="checkbox"/> Avoids reading or other near tasks       | <input type="checkbox"/> Short attention span/loses interest                |
| <input type="checkbox"/> Prefers being read to                    | <input type="checkbox"/> Poor large motor coordination                      |
| <input type="checkbox"/> Tilts head when reading                  | <input type="checkbox"/> Poor fine motor coordination                       |
| <input type="checkbox"/> Moves head when reading                  | <input type="checkbox"/> Difficulty with scissors/small hand tools          |
| <input type="checkbox"/> Confuses letter or words                 | <input type="checkbox"/> Dislikes/avoids sports                             |
| <input type="checkbox"/> Reverses letter or words                 | <input type="checkbox"/> Difficulty catching/hitting a ball                 |
| <input type="checkbox"/> Confuses right and left                  | <input type="checkbox"/> Remembers better what hears than sees              |
| <input type="checkbox"/> Skips, rereads or omits words            | <input type="checkbox"/> Difficulty recognizing same word on different page |
| <input type="checkbox"/> Loses place while reading                |   |

Do you feel your child's vision hinders his/her daily activities in any way?    Yes    No  
 If yes, how? \_\_\_\_\_  
 \_\_\_\_\_

**Visual History (cont.)**

List other members of the family who have had visual treatment and the reason:

Name	Age	Visual Situation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Have you noticed any eye turn?**                      Yes      No      (If no, skip to Medical History)

At what age did you notice or suspect eye turn? \_\_\_\_\_

Did the eye begin turning              Suddenly      Gradually (please circle one)

Does the eye turn      In      Out      Up      Down (circle all that apply)

Is the eye turn getting worse or better, or is there no change? \_\_\_\_\_

Is it always the same eye that turns?      Yes      No      Right      Left

Is the eye turn always present?              Yes      No  
If not, under what conditions is it present? (i.e. when tired, when ill, etc.) \_\_\_\_\_

Do you notice if the eye turns more when your child is looking:

Up Close	Yes	No	To his/her right	Yes	No
In distance	Yes	No	Up	Yes	No
To his/her left	Yes	No	Down	Yes	No

Has there been any treatment using an eye patch?              Yes      No  
If yes, please describe when the patching was started, how patching was done, including the age it started, the eye patched, the duration of treatment, and an estimate of the results. \_\_\_\_\_

Does the eye turn less when the prescription is worn?      Yes      No

Does one pupil ever appear to be larger than the other?                      Yes      No

Do you ever notice one or both eyes shaking rapidly?                      Yes      No

Have you ever been told that your child has amblyopia (lazy eye)?                      Yes      No

Has there been any surgical treatment?                      Yes      No  
If yes, describe the surgery, including the age surgery was performed, the number of operations, the eye operated on, an estimate of the cosmetic and subjective results. \_\_\_\_\_

Were you satisfied with the results of the surgery?                      Yes      No  
Please explain \_\_\_\_\_

Was the surgeon satisfied with the results of surgery?                      Yes      No  
Please explain \_\_\_\_\_

**Medical History**

**Does your child or anyone in your immediate family (parents, grandparents, siblings) have any of the following?**  
(Please mark all that apply and **INCLUDE** whom has/had condition)

- |  |   |
|--|---|
| <input type="checkbox"/> Amblyopia             | <input type="checkbox"/> Heart Condition      |
| <input type="checkbox"/> Autism                | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Blindness             | <input type="checkbox"/> Keratoconus          |
| <input type="checkbox"/> Brain Tumor           | <input type="checkbox"/> Learning Disability  |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Cataracts             | <input type="checkbox"/> Mutiple Sclerosis    |
| <input type="checkbox"/> Chromosomal Imbalance | <input type="checkbox"/> Strabismus           |
| <input type="checkbox"/> "Cross" or "Wall" Eye | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Surgeries            |
| <input type="checkbox"/> Epilepsy or seizure   | <input type="checkbox"/> Thyroid Conditions   |
| <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Turned or "Lazy" eye |

Date of last medical evaluation \_\_\_\_\_ Pediatrician's Name \_\_\_\_\_

For what reason? \_\_\_\_\_

Results and recommendations \_\_\_\_\_

Child's current state of health (please circle one)    **Excellent**        **Good**        **Fair**        **Poor**

List current medications and reasons for taking them \_\_\_\_\_

List current vitamins/supplements and reasons for taking them \_\_\_\_\_

Please describe any chronic conditions (ear infections, asthma, hay fever) \_\_\_\_\_

Is your child current on immunizations?    Yes    No    Any reactions to the immunizations?    Yes    No  
If yes, please explain \_\_\_\_\_

Please list serious illnesses, bad falls, high fevers, etc. \_\_\_\_\_

Is there evidence of hearing, speech or language problems? Yes    No  
If yes, please explain \_\_\_\_\_

What types of professional care has your child received or is he/she currently receiving?

Neurological  
By whom: \_\_\_\_\_ Dates: \_\_\_\_\_

Psychological  
By whom: \_\_\_\_\_ Dates: \_\_\_\_\_

Speech and Language  
By whom: \_\_\_\_\_ Dates: \_\_\_\_\_

Neuropsychological  
By whom: \_\_\_\_\_ Dates: \_\_\_\_\_

Osteopathic  
By whom: \_\_\_\_\_ Dates: \_\_\_\_\_

Physical Therapy  
By whom: \_\_\_\_\_ Dates: \_\_\_\_\_

Occupational Therapy  
By whom: \_\_\_\_\_ Dates: \_\_\_\_\_

Music Therapy  
By whom: \_\_\_\_\_ Dates: \_\_\_\_\_

Equine Therapy  
By whom: \_\_\_\_\_ Dates: \_\_\_\_\_

**Developmental History**

Full term pregnancy? Yes No  
 Did the mother experience any health problems during the pregnancy? Yes No  
 If yes, please explain \_\_\_\_\_

Normal birth? Yes No  
 Any complications before, during or immediately following delivery? Yes No  
 If yes, please explain \_\_\_\_\_

Birth weight: \_\_\_\_\_ Apgar score @ birth \_\_\_\_\_ After 10 minutes \_\_\_\_\_  
 Were forceps used? Yes No  
 Was your child breast-fed? Yes No  
 Was your child bottle fed? Yes No

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? \_\_\_\_\_  
 Speech: First word: \_\_\_\_\_ At what age? \_\_\_\_\_  
 Was speech clear to others? Yes No Is it clear now? Yes No

**Nutritional Information**

Current Diet (circle one) **Excellent** **Good** **Fair** **Poor**  
 Does your child have any food allergies? Yes No  
 If yes, please describe \_\_\_\_\_



Where is the computer screen located when your child is seated? (circle one)

Directly in front of your child

To your child's right

To your child's left

Where are your child's source documents located?

Directly in front of your child when seated

To your child's right

To your child's left

Flat (horizontal)

Vertical

Does your child experience any of the following lighting problems in his/her computer area?

Glare from windows or other light sources      Yes      No

Reflections on the computer screen              Yes      No

Difficulty reading source documents            Yes      No

Does your child wear glasses, contact lenses, or other optical devices for computer work?

Glasses                              Yes      No

Contact lenses                    Yes      No

Other (explain): \_\_\_\_\_

How many hours does your child spend in front of a computer screen each day? \_\_\_\_\_

How do your child's eyes feel after working at the computer? \_\_\_\_\_

**School**

Age at time of entrance to:      Preschool \_\_\_\_\_      Kindergarten \_\_\_\_\_      First grade \_\_\_\_\_

Does your child enjoy school?      Yes      No

Please describe any school difficulties \_\_\_\_\_

Has your child changed schools often?      Yes      No      If yes, when? \_\_\_\_\_

Has a grade been repeated?      Yes      No      If yes, which and why? \_\_\_\_\_

Does your child seem to be under tension or extreme pressure when doing school work?      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

Voluntarily    Yes      No

Does your child read for pleasure?                  Yes      No

What does your child enjoy reading? \_\_\_\_\_

What is your child's attitude towards reading, school, his/her teachers, other youngsters? \_\_\_\_\_

Overall schoolwork is: Above average                      Average                      Below average

Which subjects are:

ABOVE 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

Does the teacher feel your child is achieving up to potential?    Yes    No

**General Behavior**

Are there any behavior problems at school?                      Yes    No  
If yes, what? \_\_\_\_\_

Are there any behavior problems at home?                      Yes    No  
If yes, what? \_\_\_\_\_

What causes these problems? \_\_\_\_\_

Child's reactions to fatigue

- Irritable
- Other \_\_\_\_\_

Child's reaction to tension

- Avoidance
- Irritable
- Other \_\_\_\_\_

Does your child say and/or do things impulsively?                      Yes    No

Is your child in constant motion?                      Yes    No

Can your child sit still for long periods?                      Yes    No

**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 \_\_\_\_\_

Does your child spend time with any other person, not in the home?    Yes    No  
If yes, please explain \_\_\_\_\_

Has your child ever been through a traumatic family situation?  
(such as divorce, parental loss, separation, severe parental illness, military deployment)    Yes    No  
If yes, explain and 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 \_\_\_\_\_





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**RECORDS RELEASE/REQUEST**

TO: \_\_\_\_\_  
(Doctor/Hospital/School)

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

I hereby authorize the release of my copied medical records. I request that they be transferred to:

**Eye Priority**  
15725 South 46<sup>th</sup> Street, Suite 112  
Phoenix, AZ 85048  
Phone: (480) 893-2300  
Fax: (480) 893-0522

\_\_\_\_\_  
**Print Name of Patient**

From: \_\_\_\_\_ To: \_\_\_\_\_  
Date of Records

\_\_\_\_\_  
**Signature of Patient/Parent/Guardian** **Date**

*This authorization shall be considered valid for 12 months from date signed.*