Eye Priority, P.C.
Dr. Kelly de Simone, F.C.O.V.D.
15725 South 46th 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

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

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)

- ❑ Amblyopia
- ❑ Autism
- ❑ Blindness
- ❑ Brain Tumor
- ❑ Cancer
- ❑ Cataracts
- ❑ Chromosomal Imbalance
- ❑ "Cross" or "Wall" Eye
- ❑ Diabetes
- ❑ Epilepsy or seizure
- ❑ Glaucoma
- ❑ Heart Condition
- ❑ High Blood Pressure
- ❑ Keratoconus
- ❑ Learning Disability
- ❑ Macular Degeneration
- ❑ Mutliple Sclerosis
- ❑ Strabismus
- ❑ Stroke
- ❑ Surgeries
- ❑ Thyroid Conditions
- ❑ 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 _____

Is your child active? Not at all Moderately Extremely

Are there periods of very high energy? Yes No

Are there periods of very low energy? Yes No

Please explain _____

_____

Sports

Is your child seriously involved with athletics? Yes No

Do you feel he/she is achieving up to his/her potential in sports/athletics? Yes No

Of all the sports your child has played, list the ones in which he/she:

Excels _____

Avoids or does poorly _____

Hobbies/Leisure Time

Describe the types of activities that comprise the majority of your child's leisure time _____

_____

_____

Does your child watch TV? Yes No If yes, what is the size of the TV he/she watches? _____

Distance from TV? _____ How many days per week? _____ How many hours per day? _____

Does your child play video games? Yes No If yes, which system? _____

How many days per week? _____ How many hours per day? _____

Do you play games on the computer or TV? _____ Distance from TV or computer? _____

Size of TV of Monitor? _____

Computers

When does your child use a computer? (circle all that apply) School Leisure activity

What types of computer activities does your child perform? (circle all that apply)

Word processing
Programming
Data entry
E-mail
Internet
Games/Leisure activities
Other (explain) _____
_____

What type of computer does your child use? (circle all that apply) Laptop Desktop

Please indicate your monitor size _____

What is the distance from:

His/her eyes to the screen? _____
His/her eyes to the keyboard? _____
His/her eyes to source documents? _____

Where is the top of the screen located? (circle one)

Above eye level
At eye level
Below eye level

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 — Flat (horizontal)
To your child's right — Vertical
To your child's left

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 _____

_____

How does your child get along with:

Parents/other caretakers _____

Siblings _____

Classmates at school _____

Playmates at home _____

Did father or anyone in father's family have a learning problem? Yes No

If so, who? _____

Did mother or anyone in mother's family have a learning problem? Yes No

If so, who? _____

Give a brief description of your child as a person

_____

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

Form completed by _____

Name **Relationship to Patient**

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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 46th 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.