Eye Priority RE-Vision
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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? ____

Preferred Gender: Man/Male Woman/Female Non-Binary Prefer Not to Say

Preferred Pronouns: She/Her/Hers He/Him/His They/Them/Theirs Ze/Zir/Zirs

Address ___________________________________ City ___________________ State ______ Zip ________

Primary Phone Number _________________________ Email ____________________________________

Preferred Method of Contact: Phone Email Text

Father/Guardian Name ____ DOB _______________

Occupation ______________________________________ Employer ________________________________

Mother/Guardian Name ____ DOB ________________

Occupation ______________________________________ Employer ________________________________

Siblings' Names and Ages ____

____

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 ____

____

Has your child had a previous vision evaluation? Yes No

If yes, doctor's name _______________________________________ Date of Evaluation ________________

Reason for examination ____

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

If yes, what? ____

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 Please 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 letters or words
- ☐ Reverses letters or words
- ☐ Confuses right and left
- ☐ Skips, rereads, or omits words
- ☐ Loses place when 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? ______________________________

____

____

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

Name	Age	Visual Situation
______________________	________	______________________________________
______________________	________	______________________________________
______________________	________	______________________________________
______________________	________	______________________________________
______________________	________	______________________________________

Eye Irregularities

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

Have you noticed any eye turn? Yes No (If no, skip to the next section)

At what age did you first notice or suspect eye turn? ______________________________________

Did the eye begin turning: Suddenly Gradually

Does the eye turn: In Out Up Down

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

Is it always the same eye that turns? Yes No Which Eye? 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

In distance Yes No

To his/her left Yes No

To his/her right Yes No

Up Yes No

Down Yes No

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

Has there been any treatment using an eye patch? Yes No

If yes, please describe when the patching was started and how patching was done (include the age it started, the eye patched, the duration of treatment, and an estimate of the results) ________________________

____

____

Has there been any surgical treatment? Yes No

If yes, describe the surgery (include the age surgery was performed, the number of operations, the eye operated on, and 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 the surgery? Yes No

Please explain ____

____

Medical History

Do **your child** have any of the following:

- ☐ Autism
- ☐ Brain tumor
- ☐ Cancer Type: ____________________
- ☐ Chromosomal imbalance
- ☐ Diabetes
- ☐ Epilepsy or seizure
- ☐ Heart condition
- ☐ High blood pressure
- ☐ Mental illness Type __________________
- ☐ Multiple sclerosis
- ☐ Stroke
- ☐ Surgeries Type: ____________________
- ☐ Thyroid conditions
- ☐ Amblyopia
- ☐ Blindness
- ☐ Cataracts
- ☐ "Cross" or "wall" eye
- ☐ Glaucoma
- ☐ Keratoconus
- ☐ Macular degeneration
- ☐ Strabismus
- ☐ Turned or "lazy" eye
- ☐ Vision-related learning disability

Does **anyone in your child's immediate family** (parents, siblings, children, grandparents-note if maternal or paternal) have any of the following:

- ☐ Autism Who? ________________________
- ☐ Brain tumor Who? ____________________
- ☐ Cancer Who? ______________________
  Type: ______________________________
- ☐ Chromosomal imbalance Who? ________
- ☐ Diabetes Who? ______________________
- ☐ Epilepsy or seizure Who? ____________
- ☐ Heart condition Who? ________________
- ☐ High blood pressure Who? ____________
- ☐ Mental illness Who? ________________
  Type: ______________________________
- ☐ Multiple sclerosis Who? ______________
- ☐ Stroke Who? ________________________
- ☐ Thyroid conditions Who? ______________
- ☐ Amblyopia Who? ____________________
- ☐ Blindness Who? ____________________
- ☐ Cataracts Who? _____________________
- ☐ "Cross" or "wall" eye Who? ____________
- ☐ Glaucoma Who? _____________________
- ☐ Keratoconus Who? ___________________
- ☐ Macular degeneration Who? __________
- ☐ Strabismus Who? ____________________
- ☐ Turned or "lazy" eye Who? ____________
- ☐ Vision-related learning disability
  Who? ________________________________

Pediatrician's name ________________________________ Date of most recent evaluation ____________

For what problem/condition? ____

Results and recommendations ____

____

Child's current state of health   Excellent   Good   Fair   Poor

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 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: ________________

Medications

Please list all medications your child is currently taking (continue on back of page or attach a separate sheet if needed):

Medication Name	Reason for Taking	Dose	Frequency

Vitamins and Supplements

Please list all vitamins and/or supplements your child is currently taking (continue on back of page or attach a separate list if needed):

Vitamin/Supplement Name	Reason for Taking	Frequency

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 at 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, please explain ____

____

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? ______________

At what age did your child speak his/her first word? ____________ What was the word? ______________

Was speech clear to others? Yes No Is it clear now? Yes No

Nutritional Information

Current diet 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 performing up 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 ______________________

____

____

____

Screen Time

Does your child:

- ☐ Watch television shows, movies, or YouTube videos? Yes No
  How does he/she watch (circle all that apply): Television iPad/Tablet Cell Phone Computer/Laptop
- ☐ Play video games? Yes No
  How does he/she play (circle all that apply): Television iPad/Tablet Cell Phone Computer/Laptop
- ☐ Engage in social media? Yes No
  How does your child engage (circle all that apply): iPad/Tablet Cell Phone Computer/Laptop

How many days per week does he/she spend on these activities? ______________________________

How many hours per day does he/she spend on these activities? ______________________________

How do his/her eyes feel after engaging in these activities? ______________________________

If your child uses a television or a computer/laptop for leisure activities:

- ☐ What is the size of the screen? ______________________
- ☐ Distance from the screen? ______________________

Computers

Does your child use a computer for school? Yes No

What type(s) of computer work does your child perform (select all that apply)?

- ☐ Word processing
- ☐ Programming or coding
- ☐ Data entry
- ☐ Email
- ☐ Internet browsing
- ☐ Other (explain) ______________________________

What type of computer does your child use for school? Desktop Laptop

What is the size of the monitor? ______________________________

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 (select one)?

- ☐ Above eye level
- ☐ At eye level
- ☐ Below eye level

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

- ☐ Directly in front of him/her
- ☐ To his/her right
- ☐ To his/her left

Where are the source documents located?

- ☐ Directly in front of him/her when seated
- ☐ To his/her right
- ☐ To his/her left
- ☐ Flat (horizontal)
- ☐ Vertical

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

- ☐ Glare from windows or other light sources
- ☐ Reflections on his/her computer screen
- ☐ Difficulty reading source documents

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

- ☐ Glasses
- ☐ Contact lenses
- ☐ Other (explain) ______________________________

How many hours does your child spend in front of a computer screen for school each day? ________________

How do his/her 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 grade and why? ________________________________

____

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 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 children? _______________

____

____

Overall schoolwork is Above average Average Below average

Which subjects are above average? ____

Which subjects are 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 his/her potential? Yes No

Does the teacher feel your child is achieving up to his/her 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 response to fatigue Irritable Other _____________________________________

Child's response 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 parent(s)
- ☐ Adoptive parent(s)
- ☐ 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 (e.g., divorce, parental loss, separation, severe parental illness, military deployment)? 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 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 yes, who? ____

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

If yes, who? ____

Give a brief description of your child as a person ____

____

____

____

____

____

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

____

____

____

____

____

Form completed by: ____

Name **Relationship to Patient**

www.eyepriorityrevision.com

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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 RE-Vision
15725 S 46th Street, Suite 112
Phoenix, AZ 85048
Phone: 480-893-3999
Fax: 480-297-0503
Email: vtinfo@eyepriority.com

____
Print Name of Patient

From: ___________________________ **To:** ______________________
Date of Records Requested

____ **Date:** ___________________
Signature of Patient/Parent/Guardian

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