river view
FAMILY EYECARE

PEDIATRIC VISION QUESTIONNAIRE

OREGON
VISION DEVELOPMENT CENTER

GENERAL INFORMATION

Full Legal Name: _____ Everyday Name: _____

Birth Date: _____ Sex: Male ☐ Female ☐ Gender: _____ Pronouns: _____

Home Address: _____ City:_____ Zip: _____

Parent/Caretaker's Name: _____ Relationship: _____

Parent/Caretaker's Occupation: _____ Work Phone: _____

Email Address: _____ Cell Phone: _____

Parent/Caretaker's Name: _____ Relationship: _____

Parent/Caretaker's Occupation: _____ Work Phone: _____

Email Address: _____ Cell Phone: _____

Sibling Names and ages: _____

_____

Who's phone number is best to call regarding appointments? _____

MEDICAL HISTORY

Pediatrician's Name: _____ Date of Last Evaluation: _____

For what reason? _____

Results and recommendations: _____

_____

Child's current state of health: _____

Please list vitamins, supplements, and OTC meds: _____

_____

For what condition(s)? _____

_____

List any drug, food, environmental or other allergies: _____

_____

_____

List concussions, illnesses, bad falls, high fevers, chronic conditions, etc.:

Age Severity Complications

_____

_____

_____

Is your child generally healthy? Yes ☐ No ☐

If no, explain: _____

Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes ☐ No ☐

If yes, please list: _____

Has a neurological evaluation been performed for any reason? Yes ☐ No ☐

By whom? _____ Results/recommendations: _____

_____

Has a psychological evaluation been performed for any reason? Yes ☐ No ☐

By whom? _____ Results/recommendations: _____

_____

Has an occupational therapy evaluation been performed for any reason? Yes ☐ No ☐

By whom? _____ Results/recommendations: _____

_____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes ☐ No ☐

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

If yes, explain: _____

Normal birth? Yes ☐ No ☐

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

If yes, explain: _____

Were forceps used? Yes ☐ No ☐

Was there ever any 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? _____ At what age did you child talk? _____

Was early speech clear to others? Yes ☐ No ☐ Is speech clear now? Yes ☐ No ☐

EDUCATION

Age at time of entrance to: Pre-school _____ Kindergarten _____ First Grade _____

Current Grade: _____ School: _____

Has a grade been repeated? Yes ☐ No ☐

If yes, which and why? _____

Does your child like school? Yes ☐ No ☐

Reading level: _____

Does your child like to read? Yes ☐ No ☐

Voluntarily? Yes ☐ No ☐ For pleasure? Yes ☐ No ☐

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

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

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

Has your child had any special tutoring or remedial assistance? Yes ☐ No ☐

If yes, when? _____

Where and from whom? _____

How long? _____

Results: _____

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 ☐

Overall schoolwork is: above average ☐ average ☐ below average ☐

What is your child's attitude toward reading, school, teachers, classmates? _____

_____

On IEP/504? Yes ☐ No ☐ If yes, what accommodations are made? _____

_____

Describe any academic difficulties: _____

_____

_____

VISUAL HISTORY

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

If so, Doctor's Name: _____ Date of last evaluation: _____

Reason for examination: _____

Results and recommendations: _____

If glasses have ever been prescribed, what were they used for? _____

Any history of eye surgeries? Yes ☐ No ☐

PRESENT SITUATION

Why do you feel your child needs a visual evaluation? _____

_____

How long has this problem/difficulty been observed? _____

Is there any evidence from the school, psychological, or other tests that indicates some visual dysfunction may be present? Yes ☐ No ☐

If yes, what? _____

_____

When reading, doing schoolwork, on the computer or tablet, does your child report OR have you or anyone else noticed any of the following?

- ☐ Eye Fatigue
- ☐ Head close to paper when reading or writing
- ☐ Eye Discomfort
- ☐ Confuses letters or words
- ☐ Headaches
- ☐ Reverses letters or words
- ☐ Eyes frequently reddened
- ☐ Confuses right and left
- ☐ Frequent eye rubbing
- ☐ Difficulty recognizing the same word on different page
- ☐ Frowning
- ☐ Poor reading comprehension
- ☐ Bothered by light
- ☐ Comprehension decreases over time
- ☐ Frequent blinking
- ☐ Writes or prints poorly
- ☐ Tires easily
- ☐ Writes neatly but slowly
- ☐ Loses concentration
- ☐ Misaligns Digits or Columns
- ☐ Words, objects blur out of focus
- ☐ Frequent erasures
- ☐ Difficulty seeing distant objects
- ☐ Errors copying from the board
- ☐ Double vision
- ☐ Poor spelling

- ☐ Motion sickness / car sickness
- ☐ Responds better orally than by writing
- ☐ Dizziness
- ☐ Remembers better what hears than sees
- ☐ Words move around on the page
- ☐ Difficulty completing work in the allotted time
- ☐ Trouble remembering what was read
- ☐ Difficulty with memory
- ☐ Reads slowly
- ☐ Seems to know material, but does poorly on tests
- ☐ Skips, rereads, or omits words Short attention span / loses interest
- ☐ Loses place while reading Dislikes / avoids sports
- ☐ Closing or covering one eye Difficulty catching / hitting a ball
- ☐ Tilts head when reading or writing Difficulty with scissors / small hand tools
- ☐ Moves head when reading or writing Difficulty with sequences of directions
- ☐ Uses finger as a marker when reading
- ☐ Avoids reading or near work
- ☐ Prefers being read to
- ☐ Vocalizes when reading silently

SCREEN TIME/LEISURE TIME ACTIVITIES

How many hours of TV per day? _____ How many hours of computer/tablet/phone per day? _____

How many hours of video games per day? _____

Do you feel like your child has too much screen time? Yes ☐ No ☐

What other activities occupy your child's leisure time? _____

Are there any activities your child would like to participate in, but doesn't? _____

Please explain: _____

_____

GENERAL BEHAVIOR

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

If yes, what? _____

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) your child lives with? Mother ☐ Father ☐ Stepmother ☐

Stepfather ☐ Foster Parents ☐ Adoptive Parents ☐ Grandmother ☐ Grandfather ☐

Aunt ☐ Uncle ☐ Other Caretaker (please specify): _____

Does your child spend time with any other person, not in the home? Yes ☐ No ☐

Please explain: _____

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 ☐

Is family life stable at this time? Yes ☐ No ☐

If no, please explain: _____

How does your child get along with:

Parents/other caretakers? _____

Siblings? _____

Did your child's father, mother or siblings have a learning problem? Yes ☐ No ☐

If so, who and what? _____

_____

Please add any other information you feel would be helpful/important in our treatment of your child or any information that you would not like discussed in front of your child:

_____

_____

_____

_____

_____