

CHILDREN'S GENERAL QUESTIONNAIRE

Please fill out this questionnaire carefully. Please return to our office prior to your appointment.

Appointment: Day _____ Date _____ Time _____
 Patient's Name: _____

GENERAL INFORMATION

Were you referred? Yes ___ No ___
 If yes, by whom? _____ Phone: _____
 Address: _____
 Child's Full Name: _____ Male ___ Female ___
 Birth Date: _____ Age: ___ years ___ months
 Name and address of school: _____
 Grade ___ Teacher _____ School Nurse _____ Principal _____
 Is your child especially afraid of doctors? _____
 Child's handedness: right or left? _____
 HOME Father _____ Birth Date _____
 Mother _____ Birth Date _____
 Brothers _____ Birth Date _____
 And _____ Birth Date _____
 Sisters _____ Birth Date _____
 _____ Birth Date _____

PARENT INFORMATION

Home Address _____ City _____ State ___ Zip _____
 Home Phone _____
 Father's Employer _____ Business Phone _____
 Business Address _____ City _____ Zip _____
 Mother's Employer _____ Business Phone _____
 Business Address _____ City _____ Zip _____
 Do you have Major Medical Insurance? _____ Policy # _____
 If so, who is the carrier? _____
 Name of insured _____
 Social Security Number _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____
 Results _____
 Medications currently using (including over the counter) _____
 For what condition? _____
 Are you allergic to any medications? Yes ___ No ___
 If yes, please list. _____
 Is there any history of the following? (please check if there is a history)

	<u>Patient</u>	<u>Family</u>		<u>Patient</u>	<u>Family</u>
High Blood Pressure	_____	_____	Glaucoma	_____	_____
Heart Disease	_____	_____	Cataracts	_____	_____
Diabetes	_____	_____	Blindness	_____	_____
Thyroid Condition	_____	_____	Crossed/Turned eye	_____	_____
Multiple Sclerosis	_____	_____	Amblyopia	_____	_____
Chromosomal Imbalance	_____	_____	Brain Tumor	_____	_____

Is your child generally healthy? Yes ___ No ___
 Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes ___ No ___
 If yes, please list _____
 Have there been any previous surgeries, hospitalizations, or major injuries? Yes ___ No ___
 If yes, please explain _____

MEDICAL HISTORY (continued)

List illnesses, bad falls, high fevers, etc:

Age Severe Mild Complications

Has a neurological evaluation been performed? Yes ___ No ___
By whom? _____ Reults _____
Has a psychological evaluation been performed?. Yes ___ No ___
By whom? _____ Results _____

DEVELOPMENTAL HISTORY

Full-term pregnancy Yes ___ No ___
Normal birth? Yes ___ No ___
Were forceps used?. Yes ___ No ___
Any complications before, during, or immediately following delivery? Yes ___ No ___
Did your child crawl (stomach on floor)? Yes ___ No ___
At what age? _____
Did your child creep (stomach off floor)? Yes ___ No ___
At what age? _____
All fours? Yes ___ No ___
If not, describe _____
At what age did your child sit up (without support)? _____
At what age did your child walk (without support)? _____
Was your child active? Yes ___ No ___
If yes, was activity level low, moderate, or high? _____
Speech: First words at age _____
Was early speech clear to others? Yes ___ No ___
Is it clear now? Yes ___ No ___

NUTRITIONAL INFORMATION

Current Diet: Excellent _____ Good _____ Fair _____ Poor _____
Does your child: like sweets Yes ___ No ___
 crave sweets Yes ___ No ___
Is your child active? Yes ___ No ___
 moderately? Yes ___ No ___
 extremely? Yes ___ No ___
Are there periods of: very high energy? Yes ___ No ___
 very low energy? Yes ___ No ___

TELEVISION VIEWING

How much? _____ How often? _____ Viewing Distance _____

VISUAL HISTORY

Optometrist's Name _____ Date of Last Visit _____
Reason for examination: _____
Results _____
Were glasses/contacts prescribed? Yes ___ No ___
Are they worn? Yes ___ No ___
If yes, when are they worn? _____
Was vision therapy prescribed? Yes ___ No ___
Has your child had any eye injuries, infections, cataracts, glaucoma, retinal disease, prominent eyes,
drooping eye lids,etc.? Yes ___ No ___
If yes, please explain. _____
Has your child had any eye surgery? Yes ___ No ___
If yes, please explain _____

VISUAL HISTORY (continued)

Please list any members of the family who have had visual attention and the reason:

<u>Name</u>	<u>Age</u>	<u>Visual Situation</u>
_____	_____	_____
_____	_____	_____

PRESENT SITUATION

Is there any evidence from the preschool or psychological tests that indicates some visual malfunction may be present?Yes ___ No ___

If yes, what? _____

Does your child report any of the following:

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Headaches	___	___	_____
Blurred vision.....	___	___	_____
Double vision.....	___	___	_____
Eyes "hurt" or "tired".....	___	___	_____
Motion sickness.....	___	___	_____
Redness of the eyes.....	___	___	_____

List any other complaints your child makes concerning his/her vision: _____

HAVE YOU EVER NOTICED THE FOLLOWING:

Please check "yes" or "no" to the following observations and/or complaints as they relate to your child:

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Eyes frequently reddened	___	___	_____
Frequent eye rubbing	___	___	_____
Frequent blinking	___	___	_____
Closes or covers one eye	___	___	_____
Difficulty with drawing	___	___	_____
Head close to paper when reading or writing	___	___	_____
Tilts head when drawing or writing	___	___	_____
Tilts head when reading	___	___	_____
Moves head when reading	___	___	_____
Confuses letters or words	___	___	_____
Reverses letters or words	___	___	_____
Short attention span	___	___	_____
Poor motor coordination	___	___	_____
Difficulty catching or hitting a ball	___	___	_____
Motion sickness	___	___	_____
Skips, rereads, or omits words	___	___	_____
Loses place while reading	___	___	_____
Vocalizes when reading silently	___	___	_____
Reads slowly	___	___	_____
Uses finger as a marker	___	___	_____
Poor reading comprehension	___	___	_____
Writes or prints poorly	___	___	_____
Tires easily	___	___	_____
Crossed Eye	___	___	_____
Lazy Eye	___	___	_____

SCHOOL

Age at time of entrance to: Kindergarten _____
First Grade _____

Does your child like school? Yes ___ No ___

Does your child like his/her teacher? Yes ___ No ___

Has your child changed schools often? Yes ___ No ___
If yes, when? _____

Has a grade been repeated? Yes ___ No ___
If yes, which? _____

Does your child seem to be under tension of extreme pressure
when doing school work? Yes ___ No ___

Has your child had any special tutoring and/or remedial assistance? Yes ___ No ___
If yes, when? _____

From whom? _____

Where? _____

How long? _____

Results: _____

What school subjects are easy for your child? _____

What school subjects are difficult for your child? _____

Does your child like to read? Yes ___ No ___
Voluntarily? Yes ___ No ___

What does your child like to read? _____

Specifically describe any school difficulties: _____

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

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 ___

School work is: Above Average ___ Average ___ Below Average ___

GENERAL BEHAVIOR

Are there any behavioral problems at school? Yes ___ No ___

Are there any behavioral problems at home? Yes ___ No ___

What causes these problems? _____

Child's reaction to fatigue? sag ___ irritable ___ other ___ describe _____

Child's reaction to tension? nail-biting ___ thumb-sucking ___ other ___ describe _____

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 _____

Has your child ever been through a traumatic family situation (such as a divorce, parental loss, separation,
severe parental illness)? Yes ___ No ___

What age was he/she? _____

Does your child seem to have adjusted? Yes ___ No ___

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

How does your child get along with:
parents? _____

siblings? _____

classmates at school? _____

playmates at home? _____

Does, or did, father or anyone in father's family have a learning problem? Yes ___ No ___
If yes, who? _____

