Total Optical Child Vision Questionnaire

WELCOME TO OUR PRACTICE

CHILD'S GIVEN NAME/S:_____ SURNAME: _____

PARENT/S NAME/S:_____

ADDRESS:_____ SUBURB:_____ POSTCODE:_____

SCHOOL:_____ DATE OF BIRTH:_____/_____/_____ SEX: Male ☐ Female ☐

GRADE:_____ HOME PHONE:_____ MOBILE:_____

TEACHER'S NAME:_____ EMAIL:_____

GP's NAME:_____ GP's ADDRESS:_____

Developmental History

Birth Weight …….. Birth Order eg. First child, second, twin ……

	Yes	No				
Did child come when expected	☐	☐	Premature	☐	Overdue	☐
Did child have normal delivery	☐	☐	Caesarean	☐	Forceps	☐
Was child well after birth?	☐	☐	Humidicrib	☐	Phototherapy for jaundice	☐
Was mother well during pregnancy?	☐	☐	Any medication?	☐	Smoker	☐
Did child gain weight normally?	☐	☐	Did child bottom shuffle? Yes ☐ No ☐			

When did child say first words? …… months — At what age could child do up buttons? …… years

When did child first speak in sentences? …..…… months — At what age could child tie shoe laces? …… years

When did child correctly name colours? ……... years — At what age could child use scissors? …… years

What is child's preferred hand? Right ☐ Left ☐ At what age did child definitely become right or left handed? …….. months

Do you consider child's general co-ordination to be as expected for age? Yes ☐ No ☐

General Health

Has child had any serious illness or injury requiring hospitalisation? Yes ☐ No ☐ If yes, details please……..……

……

Has child had any episode of high fever for more than 48 hours? Yes ☐ No ☐ If yes, details please……..……..……

……

Has child a history of recurrent ear problems? Yes ☐ No ☐ Have tubes been inserted? Yes ☐ No ☐

Does child suffer from any other chronic or recurrent illness (eg. asthma, epilepsy) Yes ☐ No ☐ If yes, details please

……

Has child been diagnosed with Attention Deficit Disorder (ADD)? Yes ☐ No ☐

Has child had: speech therapy? Yes ☐ No ☐ Occupational therapy? Yes ☐ No ☐

Does child take any medication? Yes ☐ No ☐ If yes, please list ……...

Does child live with both parents? Yes ☐ No ☐

Visual History

	Yes	No	
Does one eye turn in or out?	☐	☐	If yes, when was this first noticed?.....
How often is turn noticed?.....			When is turn noticed? (eg when eating, drawing)……..
Has child had a previous visual examination?	☐	☐	If yes, when was the last exam?.....
Were glasses prescribed?	☐	☐	
Has patching of one eye been prescribed?	☐	☐	If yes, how long was patch worn? ……
Does child dislike bright light especially when outside?	☐	☐	Does child screw up one eye when in bright light? Yes ☐ No ☐

Educational History

	Yes	No		Yes	No
Has child's school progress been as expected for ability?	☐	☐	Has child repeated a grade?	☐	☐
Does child have difficulty with – reading?	☐	☐	Has there been any remedial		
- writing?	☐	☐	teaching?	☐	☐
- spelling?	☐	☐	School based	☐	☐
- maths?	☐	☐	Private tutor	☐	☐

Observable behaviours possibly related to vision problems.

Please tick the box next to any problem that seems to occur often for your child.

Signs of Focusing and Eye Teaming Problems

- Covers or closes one eye when reading ☐
- Complains of eye strain ☐
- Complains of headache ☐
- Complains of double vision ☐
- Complains of blurred vision when reading ☐
- Rubs eyes ☐
- Complains of words moving on the page ☐
- Inattentive ☐
- Poor reading comprehension ☐
- Loses place when reading ☐
- Complains of blurred vision looking from desk to board ☐
- Holds books very close ☐

Signs of Tracking Problems

- Loses place often ☐
- Skips words and lines often ☐
- Uses finger to keep place ☐
- Short attention span when reading ☐

Signs of Visual Processing Disorders

- Trouble learning left and right ☐
- Reverses letters and numbers ☐
- Mistakes words with similar beginnings ☐
- Poor recall of visually presented material ☐
- Slow copying and completing worksheets ☐
- Can respond orally but not in writing ☐
- Trouble learning basic maths concepts of size and magnitude ☐
- Untidy writing ☐
- Trouble copying from board to book ☐
- Doesn't recognise the same word on a repeated page ☐
- Trouble with spelling and sight word vocabulary ☐
- Seems to know material, but does poorly on tests ☐
- Erases excessively ☐
- Poor reading comprehension yet good comprehension when read to (listening) ☐

HOW DID YOU FIRST HEAR ABOUT OUR PRACTICE?

Personal recommendation of: (Please name the person we can thank for recommending you to our practice!)

- ☐ Friend or Relative — Who: _____
- ☐ Health Care Practitioner — Who: _____
- ☐ Previous patient — Who: _____
- ☐ Community Event — Which: _____
- ☐ Teacher — Who: _____
- ☐ Other: _____

- ☐ Yellow Pages
- ☐ Yellow Pages Online
- ☐ White Pages
- ☐ White Pages Online

DO YOU HAVE HEALTH FUND EXTRAS (OPTICAL COVER)? Yes ☐ No ☐

Health Fund Name: _____

YOUR PRIVACY

At Total Optical your privacy is our priority. Your personal information that we collect and hold about you is handled with the utmost confidentiality and security and in accordance with the Privacy Act. For more information on how we manage your privacy, or for a copy of our privacy policy, please contact our practice.

From time to time we may send you information on education relating to eye care and diseases, promotional offers and invitations to events and our practice newsletter. Do we have your permission to send this material to you? ☐ *YES* ☐ *NO*

I authorise that all the information I have provided you is correct. I consent to the release of confidential information from my child's medical records in the understanding that this will be done for the benefit of my child's visual or medical welfare.

Signature: _____ *Date:* _____