Visual Health & Learning Center
Dr. Jenna Williams McDermed
Development Optometry

CHILD QUESTIONNAIRE

Today's Date: _____

Patient's Full Name: _____ D.O.B.:_____ Age: _____ □ Male □ Female

Address: _____City: _____State: _____ Zip Code: _____

Parent Name: _____ Occupation: _____ Cell:_____

Parent Name: _____ Occupation: _____ Cell:_____

Home Phone: _____ Family Email: _____

School: _____ Grade: _____

Primary Physician: _____ Phone: _____

Referred by: _____

CHIEF COMPLAINT/ MAJOR CONCERN:

Briefly explain the concerns that prompted you to come to our office: _____

_____

_____

Who first noted visual difficulties? _____ When: _____

VISUAL HISTORY:

Has there been previous comprehensive visual exam? □ NO □ YES If yes, date of last exam _____/_____/_____

Name of Eye Doctor: _____ Address: _____

Please provide any information regarding glasses, patching, vision therapy, ocular medication, or surgery:

_____

Please list any unusual signs or symptoms that concern you? _____

Has your child's ability to do any activity been restricted because of vision? □ NO □ YES

Please explain: _____

HEALTH HISTORY: *Check any conditions that apply to your child or run in your family.*

Allergies	□ Child	□ Family	**Lazy Eye**	□ Child	□ Family
Respiratory disease	□ Child	□ Family	**Turned Eye**	□ Child	□ Family
Drug Sensitive	□ Child	□Family	**Glaucoma**	□ Child	□ Family
Cancer	□ Child	□Family	**Dry eyes**	□ Child	□ Family
Diabetes	□ Child	□Family	**Eyestrain**	□ Child	□ Family
Thyroid	□ Child	□ Family	**Light sensitive**	□ Child	□ Family
Heart problem	□ Child	□ Family	**Floaters/spots**	□ Child	□ Family
High blood pressure	□ Child	□ Family	**Flashing lights**	□ Child	□ Family
Head trauma	□ Child	□ Family	**Blindness**	□ Child	□ Family
Migraine/headache	□ Child	□ Family	**Cataracts**	□ Child	□ Family
Retinal detachment	□ Child	□ Family	**Eye Surgery**	□ Child	□ Family
Color "blind"	□ Child	□ Family	**Eye Injury**	□ Child	□ Family

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Is your child currently under a physician's care? □ NO □ YES Why? _____

Date of child's last physical? _____ How is child's general health? _____

Is your child regularly taking pills or medications? □ NO □ YES Specify_____

List any allergies to medications_____

Is there any history of ear infection? □ NO □ YES How often?_____

Has there been any auditory testing? □ NO □ YES

Indicate date of testing and results:_____

Is there a history of asthma? □ NO □ YES Is there a history of epilepsy or seizures? □ NO □ YES

DEVELOPMENTAL & GENETIC HISTORY*:*

Check any conditions that apply to your child or run in your family.

ADD/ADHD	□ Child □ Family	**Dyslexia**	□ Child □ Family
Auditory Processing Disorder	□ Child □ Family	**Dyscalculia**	□ Child □ Family
Autism Spectrum Disorder	□ Child □ Family	**Dysgraphia**	□ Child □ Family
Cerebral Palsy	□ Child □ Family	**Down Syndrome**	□ Child □ Family
Bipolar Disorder	□ Child □ Family	**Language Disorder**	□ Child □ Family
Degenerative Disorder	□ Child □ Family	**Sensory Related Difficulties**	□ Child □ Family
Low Muscle Tone	□ Child □ Family		

*List any illnesses or developmental/genetic diagnoses not specified: _____

FAMILY HISTORY:

Is there a family history of significant reading, writing, and/or spelling difficulties? □ NO □ YES

If Yes, who?_____Describe:_____

Is there a family history of hyperactivity, attention problems, and/or speech difficulties? □ NO □ YES

If Yes, who?_____Describe: _____

Is there a family history of eye turns and/or lazy eyes? □ NO □ YES

If Yes, who?_____Describe: _____

DEVELOPMENTAL MILESTONES:

Full Term Pregnancy: □ NO □ YES **Normal Birth?** □ NO □ YES

C-Section? □ NO □ YES **Forceps Used?** □ NO □ YES

Complications before, during, or immediately following delivery? □ NO □ YES

Please Describe: _____

Any serious/major falls, injuries or illness? □ NO □ YES Explain:_____

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MOTOR: When did your child:

Creep (stomach on floor)? ☐ Never ☐ Early ☐ Average ☐ Late

Crawl (move on all fours)? ☐ Never ☐ Early ☐Average ☐ Late

For how long did your child creep/crawl? ☐ Average ☐ Long ☐ Short

Walk? ☐ Early ☐ Average ☐ Late

Was Occupational Therapy Required? ☐ NO ☐ YES What Age(s)?_____

SPEECH:

Child's first words were: ☐ Early ☐ Average ☐ Late

Was early speech clear to others? ☐ Yes ☐ No

Is child's speech clear now? ☐ Yes ☐ No

Was Speech Therapy Required? ☐ NO ☐ YES What Age(s)?_____

EDUCATIONAL INFORMATION:

Has a grade been repeated? ☐ NO ☐ YES If so, which grade/s? _____

Is school work average or above? ☐ NO ☐ YES

Do you feel he/she is working up to potential? ☐ NO ☐ YES

What school subjects are difficult for your child? _____

Has your child had any evaluations (psychological, special educational, speech and language, neurological, etc.) at school or elsewhere? ☐ NO ☐ YES *Indicate type of testing and date:

_____

Does your child currently receive any special services/therapies (speech, language, occupational, physical, tutor, etc.)?

☐ NO ☐ YES *Indicate type and how often:

_____

Is your child in a specialized classroom setting (self-contained, AG, resource, etc.) or have an IEP or 504 Plan?

☐ NO ☐ YES *Indicate what type:

_____

Has your child's teacher reported any concerns about school performance or attention:

☐ NO ☐ YES If Yes explain: _____

Has Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) been diagnosed?

☐ NO ☐ YES *Indicate the date of diagnosis _____

Was Medication Recommended? ☐ NO ☐ YES

Has you child ever used ADD/ADHD Medications? ☐ NO ☐ YES

Is your child currently using ADD/ADHD Medication? ☐ NO ☐ YES

If yes, does it help? ☐ NO ☐ YES

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RECREATION AND LEISURE:

In what recreational activities does your child participate? (Please Circle)

Read, Baseball, Basketball, Soccer, Swim, Football, Tennis, Build Models, Sew, Dance, Play an instrument.

Other recreational or sports activities _____

Does your child watch much television?	☐ Never	☐ Sometimes	☐ A lot
Does your child use a computer at home?	☐ Never	☐ Sometimes	☐ A lot
Does you child often play video games?	☐ Never	☐ Sometimes	☐ A lot
Does your child read?	☐ Never	☐ Sometimes	☐ A lot

Does your child report or have you noticed any of the following? Please check (√) all areas of concern.

☐ Does not judge distance accurately
☐ Blur when looking at near
☐ Sees worse at the end of the day
☐ Double vision
☐ Falls asleep reading
☐ Dizzy/nausea with near work
☐ Poor/inconsistent in sports
☐ Avoids sports/games
☐ Poor handwriting
☐ Car/motion sickness
☐ Does not make change well
☐ Letter/word reversals

	NEVER	ONCE IN A WHILE	SOMETIMES	A LOT	ALWAYS
Headaches with near work					
Words run together reading					
Burn, Itch, Watery eyes					
Skips/Repeats lines reading					
Head tilt/ Close one eye when reading					
Difficulty copying from chalkboard					
Avoids near work/reading					
Omits small words when reading					
Writes up/down hill					
Misaligns digits/columns numbers					
Reading comprehension down					
Holds reading too close					
Trouble keeping attention on reading					
Difficult completing assignments on time					
Always says “I can’t” before trying					
Clumsy, knocks things over					
Does not use his/her time well					
Loses belongings/things					
Forgetful/poor memory					

XO_____ X1_____ X2_____ X3_____ X4_____

TOTAL SCORE_____

Child's Name_____

Dilation Consent

Florida Board of Optometry & the American Optometric Association recommend a dilated eye examination to fully assess the health of your eyes. Without dilation, a condition with the potential for the partial or total loss of vision may exist & go undetected. Dilation is part of a complete eye examination and does not cost extra.

Dilation will cause sensitivity to light & will make your child's near vision blurry temporarily. Our office will provide you with disposable sunglasses to minimize you sensitivity. If you have any questions, the Doctor will be happy to discuss dilation with you.

☐ **Yes, I want my child's eyes dilated today.**
☐ **No, I do not want my child's eyes dilated today, but I will reschedule the dilation.**
☐ **No, I choose not to have my child's eyes dilated.**

Acknowledgement of Receipt of Privacy Practices

I acknowledge that I have received or had access to a copy of the privacy practices at the Visual Health & Learning Center.

Signed_____ Relationship_____ Date _____

Authorization of Treatment

I authorize my child to be examined and treated. I understand that the Visual Health & Learning Center is an Out-of-Network Provider for all Insurance Companies. Therefore, payment is required at the date of service. I am responsible to pay for services and hereby authorize release of pertinent information to insurance carriers for reimbursement directly to the patient.

Signed_____ Relationship_____ Date _____