CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
Developmental Optometrist

Dr. Marija Novakovich
Developmental/Pediatric/
Neuro-Optometric

Dr. Dana Shannon, FAAO
Optometrist

CHILDREN'S 0-3 YEARS VISION QUESTIONNAIRE

Child's Name: _____ Male _____ Female _____
Birth Date: _____ Age: _____years _____months
Reason for Visit: _____
Were you referred to our office? Yes ☐ No ☐
If yes, whom may we thank for this referral? _____
If not referred, how did you learn about our office? _____

RESPONSIBLE PERSON INFORMATION:

Father/Caretaker Name:_____ Cell Phone: _____
Occupation:_____
Mother/Caretaker Name:_____ Cell Phone: _____
Occupation:_____

PATIENT'S MEDICAL HISTORY:

Pediatrician's Name:_____Phone Number: _____
Medications currently used, including vitamins and supplements:

1. _____ Condition: _____
2. _____ Condition: _____
3. _____ Condition: _____
4. _____ Condition: _____

Allergies to foods or medications. If yes, please list:_____

List illnesses, bad falls, high fevers, etc.:

	Illness	Age	Severity (Mild-Severe)	Complications
1.				
2.				

Is your child generally healthy? Yes ☐ No ☐
If no, explain: _____
Has an occupational therapy evaluation been performed? Yes ☐ No ☐
If yes, by whom? _____
Results and recommendations: _____
Has a speech therapy evaluation been performed? Yes ☐ No ☐
If yes, by whom? _____
Results and recommendations: _____
Has your child been evaluated by any other medical specialist? Yes ☐ No ☐
If yes, by whom? _____
Results and recommendations: _____

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

Diabetes	☐ Child	☐ Family	Epilepsy/Seizures	☐ Child	☐ Family
High blood pressure	☐ Child	☐ Family	Color "blind"	☐ Child	☐ Family
High Cholesterol	☐ Child	☐ Family	Nearsighted	☐ Child	☐ Family
Thyroid	☐ Child	☐ Family	Farsighted	☐ Child	☐ Family
Heart problem	☐ Child	☐ Family	Refractive Eye Surgery (Lasik, PRK)		☐ Family
Cancer	☐ Child	☐ Family	Glaucoma	☐ Child	☐ Family
Respiratory Disease	☐ Child	☐ Family	Cataracts		☐ Family
Ear/Nose/Throat Problems	☐ Child	☐ Family	Macular degeneration		☐ Family
Muscle/Bone/Joint Problems	☐ Child	☐ Family	Retinal Detachment	☐ Child	☐ Family
GI Problems	☐ Child	☐ Family	Blindness	☐ Child	☐ Family
Skin Problems	☐ Child	☐ Family	Lazy Eye	☐ Child	☐ Family
Psychiatric Problems	☐ Child	☐ Family	Crossed Eyes	☐ Child	☐ Family
Allergies/Immunologic Problems	☐ Child	☐ Family	ADD/ADHD	☐ Child	☐ Family
Migraines/headaches	☐ Child	☐ Family	Learning Disability	☐ Child	☐ Family
Head Trauma/Concussion	☐ Child	☐ Family	Dyslexia	☐ Child	☐ Family

Other medical conditions:_____

_____

DEVELOPMENTAL HISTORY:

Was the pregnancy full term? Yes ☐ No ☐

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

If yes, explain: _____

Did the mother smoke, drink alcohol, use legal or illegal drugs? Yes ☐ No ☐

If yes, explain: _____

Were there any complications before, during or immediately following delivery? Yes ☐ No ☐

If yes, explain: _____

Birth weight: _____ Apgar scores @ birth: _____ After 10 minutes: _____

Was there ever any reason for concern over your child's general growth or development?

If yes, explain: _____

DEVELOPMENTAL MILESTONES: Please list the age your child was able to complete the following tasks:

Age: Task

_____ Crawl on stomach on the floor

_____ Crawl on all fours

_____ Walk

_____ First words. Was speech clear to others? Yes ☐ No ☐ Is speech clear now? Yes ☐ No ☐

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OCULAR 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: _____

Were glasses or other optical devices recommended? Yes ☐ No ☐

If yes, what type? _____

Are they used? Yes ☐ No ☐ If yes, when? _____

If not used, why not? _____

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING IN YOUR CHILD:

	Yes	No	If yes, when, and how often?
Eyes frequently reddened	☐	☐	
Frequent eye rubbing	☐	☐	
Frequent styes	☐	☐	
Frowning	☐	☐	
Bothered by light	☐	☐	
Frequent blinking	☐	☐	
Closing or covering one eye	☐	☐	
Do eyes deviate or turn	☐	☐	
Does child squint	☐	☐	
Head close to paper when doing near tasks	☐	☐	
Dislikes/avoids near tasks	☐	☐	
Turns/Tilts head when doing near tasks (coloring, reading)	☐	☐	
Turns/Tilts head when doing distance tasks (TV, outside)	☐	☐	
Easily makes eye contact	☐	☐	
Does child engage with pictures	☐	☐	
Difficulty following instructions	☐	☐	
Poor large motor coordination	☐	☐	
Poor fine motor coordination	☐	☐	
Clumsy, tends to fall often	☐	☐	
Uncomfortable in new places	☐	☐	

GENERAL BEHAVIOR:

Are there any behavior problems (play groups, play dates)? Yes ☐ No ☐

If yes, what? _____

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

If yes, what? _____

What causes these problems? _____

How does your child react to fatigue? sad ☐ irritable ☐ other ☐

How does your child react to tension? avoidance ☐ irritable ☐ other ☐ _____

Does your child say and/or do things impulsively? Yes ☐ No ☐

Is your child in constant motion? Yes ☐ No ☐

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GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON: _____

IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL/IMPORTANT IN OUR TREATMENT OF YOUR CHILD?