**Dr. Monika Spokas**
Developmental Optometrist

**Dr. Amber Cumings,** FAAO
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**Dr. Delia Malone**
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# CHILDREN'S PREREADER 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? ______________ Phone: ______________
Address: ______________________________ Email Address: ______________

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:______________________

Name and address of school: ______________________________
Grade: _____ Teacher: ______________________ School Nurse: ______________
Social Worker: ______________________ Principal: ______________

RESPONSIBLE PERSON INFORMATION:
Home Address:______________________City: ______________Zip: ________
Home Phone: ______________________Mother/Father Cell Phone: ______________
Father/Caretaker's Occupation:______________________ Place of Employment: ______________
Business Phone:______________________Email Address: ______________
Mother/Caretaker's Occupation: ______________________Place of Employment: ______________
Business Phone: ______________________Email Address: ______________

## 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:______________________________

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

| | Illness | Age | Severity (Mild-Severe) | Complications |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

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? Yes ☐ No ☐
If yes, by whom? ______________________________
Results and recommendations: ______________________________

Has a psychological evaluation been performed? Yes ☐ No ☐
If yes, by whom? ______________________________
Results and recommendations: ______________________________

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: ______________________________

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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CLARENDON
VISION
DEVELOPMENT
CENTER

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

| Condition | Child | Family | Condition | Child | 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: ______________________________________________

______________________________________________

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: ______________________________________________

Wears glasses, contact lenses, or other optical devices recommended? Yes ☐ No ☐
If yes, what type? ______________________________________________
Are they used? Yes ☐ No ☐ If yes, when? ______________________________
If not used, why not? ______________________________________________

DOES YOUR CHILD REPORT ANY OF THE FOLLOWING:

| | Yes | No | If yes, when and how often? |
|---|---|---|---|
| Headaches | ☐ | ☐ | ______________ |
| Blurred vision | ☐ | ☐ | ______________ |
| Double vision | ☐ | ☐ | ______________ |
| Eyes hurt | ☐ | ☐ | ______________ |
| Eyes tired | ☐ | ☐ | ______________ |
| Motion sickness / car sickness | ☐ | ☐ | ______________ |
| Dizziness | ☐ | ☐ | ______________ |

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## 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 | ☐ | ☐ | ______ |
| Difficulty seeing distant objects | ☐ | ☐ | ______ |
| 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) | ☐ | ☐ | ______ |
| Will not make eye contact | ☐ | ☐ | ______ |
| Difficulty following instructions | ☐ | ☐ | ______ |
| Poor large motor coordination | ☐ | ☐ | ______ |
| Poor fine motor coordination | ☐ | ☐ | ______ |
| Cannot keep coloring or drawing on paper | ☐ | ☐ | ______ |
| Cannot color within the lines | ☐ | ☐ | ______ |
| Difficulty copying simple forms or letters | ☐ | ☐ | ______ |
| Difficulty counting objects (stacked blocks) | ☐ | ☐ | ______ |
| Difficulty with sensory tasks (Play-Doh, finger paint) | ☐ | ☐ | ______ |
| Clumsy, tends to fall often | ☐ | ☐ | ______ |
| Tires easily | ☐ | ☐ | ______ |
| Short attention span / loses interest | ☐ | ☐ | ______ |
| Poor balance | ☐ | ☐ | ______ |
| Uncomfortable in new places | ☐ | ☐ | ______ |
| Difficulty with scissors / small hand tools | ☐ | ☐ | ______ |
| Dislikes / avoids sports | ☐ | ☐ | ______ |
| Difficulty catching / hitting a ball | ☐ | ☐ | ______ |

## ELECTRONIC USE/LEISURE TIME ACTIVITIES:

How much time does your child spend on electronics outside of school? Avg per day______________________

How much time does your child spend outside? Avg per day______________________

## SCHOOL:

At what age did your child begin school: Pre-school:______ Kindergarten: ______

Does your child like school? Yes ☐ No ☐

Does your child like their teacher? Yes ☐ No ☐

Has your child had any special tutoring, therapy, and/or remedial assistance? Yes ☐ No ☐

If yes, when? ______________________

Where and from whom? ______________________

How long? ______________________

Results: ______________________

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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 ☐

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?

______________________________

______________________________

______________________________

______________________________

______________________________

## RETINAL IMAGING

We are pleased to provide our patients with an advanced digital retinal exam. It is great for documenting a baseline image for our charts, screen for eye diseases, and improve our ability to view your internal retinal health. A dilated exam may still be recommended by the doctor if a more peripheral view of the retina is indicated. Since insurance only covers retinal photos after eye disease is discovered, the Retinal Imaging Exam is an out-of-pocket expense. The fee is $45.00.

☐ I want my child to have the retinal health evaluated with Retinal Imaging.

☐ I do not wish to have Retinal Imaging Exam for my child. I understand that a thorough eye exam with dilation will be performed.

Signature ______________________________ Date ______________

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