CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
Developmental Optometrist

Dr. Marija Novakovich
Developmental/Pediatric/
Neuro-Optometric

Dr. Dana Shannon, FAAO
Optometrist

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: _____

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

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: _____

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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 ☐

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:_____

_____

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? _____

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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	☐	☐	

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_____

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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: _____

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?

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WELLNESS ASSESSMENT

Introducing Our Enhanced Eye Wellness Exam! Experience the next level of eye care with our Eye Wellness Exam, now including a fundus photo. This advanced digital retinal exam offers several benefits for your eye health. Firstly, it allows us to assess the health of your macula, which is vital for clear central vision. Additionally, it helps us screen for common eye diseases such as macular degeneration and glaucoma. The exam establishes a baseline for your eye health history, aiding in the early detection of any vital changes. It's important to note that insurance typically covers retinal photos only when an eye disease is already detected. In certain instances, the doctor might suggest a dilated exam to obtain a more thorough view of your retina, but only if deemed necessary based on the findings of this examination. Your eye health is our priority, and we're committed to providing you with the best care possible. The Retinal Imaging Exam comes at an out-of-pocket cost of $55.00.

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

☐ I do not wish to have the Retinal Imaging Exam. I understand that I will still have a thorough eye exam with possible dilation.

Signature _____ Date _____