CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
Developmental Optometrist

Dr. Marija Novakovich
Developmental/Pediatric/
Neuro-Optometric

Dr. Dana Shannon, FAAO
Optometrist

CHILDREN'S SCHOOL AGE 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: _____

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.				
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: _____

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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: _____

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: _____

_____

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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 ☐

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 / focus goes in and out	☐	☐	
Words move around on the page	☐	☐	
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	☐	☐	

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	Yes	No	If yes, when and how often?
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 reading	☐	☐	
Tilts head when reading/writing	☐	☐	
Moves head when reading	☐	☐	
Confuses letters or words	☐	☐	
Confuses right and left	☐	☐	
Reverses letters or words	☐	☐	
Skips, rereads or omits words	☐	☐	
Loses place while reading	☐	☐	
Vocalizes when reading silently	☐	☐	
Reads slowly	☐	☐	
Uses finger as a marker	☐	☐	
Poor reading comprehension	☐	☐	
Comprehension decreases over time	☐	☐	
Difficulty copying from white board	☐	☐	
Difficulty recognizing same word on a different page	☐	☐	
Poor word attack skills	☐	☐	
Difficulty with memory	☐	☐	
Remembers better what hears than sees	☐	☐	
Responds better orally than by writing	☐	☐	
Seems to know material, but does poorly on tests	☐	☐	
Poor sequencing	☐	☐	
Writes or prints poorly	☐	☐	
Writes neatly but slowly	☐	☐	
Awkward or immature pencil grip	☐	☐	
Frequent erasures	☐	☐	
Dislikes / avoids near tasks	☐	☐	
Avoids making eye contact	☐	☐	
Difficulty following instructions	☐	☐	
Short attention span / loses interest	☐	☐	
Tires easily	☐	☐	
Poor large motor coordination	☐	☐	
Poor fine motor coordination	☐	☐	
Difficulty with scissors / small hand tools	☐	☐	
Dislikes / avoids sports	☐	☐	
Difficulty catching / hitting a ball	☐	☐	
Clumsy, tends to fall often	☐	☐	
Poor balance	☐	☐	
Uncomfortable in new places	☐	☐	

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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 changed schools often? Yes ☐ No ☐

If yes, when? _____

Has a grade been repeated? Yes ☐ No ☐

If yes, which and why? _____

Is your child under tension or pressure when doing schoolwork? Yes ☐ No ☐

If yes, please explain? _____

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

If yes, when? _____

Where and from whom? _____

How long? _____

Results: _____

Does your child like to read? Yes ☐ No ☐

Does your child read voluntarily? Yes ☐ No ☐

Does your child read for pleasure? Yes ☐ No ☐

What does your child read for pleasure (i.e., graphic novels, short stories, comic books etc.)? _____

_____

Overall schoolwork is: above average ☐ average ☐ below average ☐

Does your child need to spend a lot of time/effort to maintain this level of performance?

Yes ☐ No ☐

How much time on average does your child spend each day on homework assignments? _____

To what extent do you assist your child with homework? _____

Do you feel your child is achieving up to potential? Yes ☐ No ☐

Does the teacher feel your child is achieving up to potential? Yes ☐ No ☐

WHICH SUBJECTS ARE:

Above average: _____

Average: _____

Below average: _____

Specifically describe any school difficulties:

_____

_____

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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?

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 _____