

QUESTIONNAIRE FOR CHILDREN NEW TO OUR CLINIC

Sally K Doyle BScOptom (Melb) FVCO Cert Therapeutics
Jane Duffy BScOptom (Melb) FVCO Lib Cert Therapeutics
Lauren Cowan BScOptom (Melb) Cert Therapeutics

We ask you to take a few moments to complete this form. The purpose of collecting this information is to assist us in providing your child with the highest quality eye-care. All information will be treated in the strictest confidence in accordance with the Privacy Act. As you complete this history questionnaire we hope that you will recognize the thoroughness with which your child's vision will be considered. The examination will take up enough time to permit a very complete investigation. It is desirable to have both parents present during the examination when possible. If Digital Retinal Imaging is required there will be a fee of \$35.00

Child's Full name: _____ **Date of birth:** _____

Complete Medicare no: _____ EXPIRY _____

Please sign here to give us permission to contact Medicare if we need to clarify information regarding item numbers:

Signature: _____ Private Health Fund _____

Address _____ Parent **email** _____

Mother's /carer's name _____ Phone/s _____

Father's/ carer's name _____ Phone/s _____

Siblings (age and gender) _____

In what ways does your child seem to have difficulty? How does your child report vision difficulties?

Please detail any family members (even cousins/aunts/uncles) who have a history of vision problems, particularly in childhood

How long has difficulty been noticed? _____

What do you hope to find out from the examination? _____

Has your child previously seen another optometrist/ophthalmologist? _____

Were you referred here by another professional? please detail _____

Reason for referral _____

General practitioner who knows your child/address _____

Pediatrician's name/address (if applicable) _____

Last medical exam _____ Allergies _____

Present medications _____

Give a brief description of your child/any other information you think will help to introduce us to your child:

Developmental history

Full term pregnancy? _____ Normal birth? _____

Any complications before, during, or following delivery? _____

Did your child crawl? Yes No Age _____ Age at which child walked? _____

Under tension, is there any pattern of behavior, thumb-sucking, etc? _____

When fatigued, child will: Sag _____ Becomes irritable _____ excited _____

Age of speech: First words? _____ Sentences? _____

Does your child have speech or language deficit? Yes No please detail _____Has your child received speech therapy Yes No please detail _____*[If your child was adopted or early childhood history not known please indicate here: _____]***Vision related symptoms**

Does your child ever report any of the following, and if yes, when?

Headaches Yes No Eyes hurt or tired Yes NoBlurred Vision Far Yes No Double Vision Yes NoBlurred at Near Yes No Light sensitivity Yes NoEyes frequently red? Yes No Excessive eye rubbing? Yes NoClosing/covering one eye? Yes No Eye turns in or wander out? Yes No**Reading related symptoms**Does your child like to read? Yes No Holds book too close/far away Yes NoMoves lips while reading quietly Yes No Skips words or rereads Yes NoReverses words/letters Yes No Distorted posture when reading Yes NoGet lost in book? Yes No Moves head while reading Yes NoUses finger to follow words Yes No Tilts head while reading Yes No**Educational Information**

Child's School (if school age) _____ Grade/Year Level _____ Teacher's Name _____

Is your child's school work? average better than average below average

Does child like school? _____ Was a grade repeated? _____ Which one? _____

What subjects are considered easiest? _____ most difficult? _____

Does the school consider your child to have a learning problem? Yes No _____