Developmental Vision Care, P.C. Kenneth R. Westcott, O.D.
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Children's Vision Questionnaire—Extended

Please fill out this questionnaire carefully. Please return it to our office at your scheduled appointment time. THANK YOU.

Patient's Name:_____
Appointment: Day _____ Date _____ Time _____

As you complete this form you will recognize the thoroughness with which your child's problem will be considered. This history questionnaire serves several purposes. It will allow you to refer to baby books and other records for more accurate answers. It gives us more time to spend with your child while in the office for the actual examination because this part of the case record will have already been completed. It allows us to plan in advance for the tests and examination routines which will best apply to your child's problems. It also reflects the multi-professional team approach that we take. With the information that you provide we can consult with other professionals who have evaluated your child and recommend other providers if non-visual problems are detected during our evaluation.

You might wonder, since this is a visual examination, why some of these questions are asked. Each question has been carefully designed to give us the most complete picture of your child and their development. Two questions in the Developmental History section are a good example for explanation. Ages at the time of first walking and talking are requested. From these we can determine early visual behaviors by comparison to walking and talking development. If a question arises, please put a '?' in the margin and we will be happy to discuss this with you at the time of the exam or if your question is of a more pressing nature you may call our office beforehand. Please be as accurate and complete as possible.

GENERAL INFORMATION

Were you referred to our office? Yes ☐ No ☐
If yes, whom may we thank for this referral? _____ Phone: _____
Address: _____
Child's Full Name: _____ Likes to be called: _____
Birth Date: _____ Age: _____years _____months Male ☐ Female ☐
Is your child especially afraid of doctors? Yes ☐ No ☐ Afraid of eye drops? Yes ☐ No ☐

Please list the names and birth dates of the members of your family:

	Name	Birth Date	Occupation or Grade
Father/Caretaker	_____	_____	_____
Mother/Caretaker	_____	_____	_____
Sibling	_____	_____	_____
Sibling	_____	_____	_____
Sibling	_____	_____	_____
Sibling	_____	_____	_____

Home Address: _____ City: _____ State: ____ Zip: _____
Home Phone: (____) _____
Parent (dad/mom) Cell Phone: (____) _____ Parent (dad/mom) Cell Phone: (____) _____
Parent (dad/mom) E-mail: _____
Parent (dad/mom) E-mail: _____

Responsible Party
Name: _____ Relationship to Patient: _____
Social Security Number: _____
Place of Employment: _____ Work Phone Number: _____
Business Address: _____ City: _____ State: ____ Zip: _____

In order for us to keep costs down, payment is expected in full at the time of service.

Present Situation

What are your primary concerns about your child? _____

_____

In what ways does your child seem to have difficulties? _____

_____

How long has this problem/difficulty been observed? _____

How does your child complain about his or her vision? _____

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

Blurred vision at far No ☐ Yes ☐ _____
Blurred vision at near No ☐ Yes ☐ _____
Eyes hurt or tired No ☐ Yes ☐ _____
Headaches No ☐ Yes ☐ _____
Double vision No ☐ Yes ☐ _____
Words moving on the page No ☐ Yes ☐ _____
Flashes/floaters No ☐ Yes ☐ _____
Motion sickness/car sickness No ☐ Yes ☐ _____
Dizziness No ☐ Yes ☐ _____

Have you or anyone else noticed the following, and if yes, when and under what conditions?

Eyes frequently reddened No ☐ Yes ☐ _____
Excessive eye rubbing No ☐ Yes ☐ _____
Frequent sties No ☐ Yes ☐ _____
Light sensitive No ☐ Yes ☐ _____
Frequent blinking No ☐ Yes ☐ _____
Closing or covering one eye No ☐ Yes ☐ _____
Head close to paper when reading or writing No ☐ Yes ☐ _____
Avoids (dislikes) reading or near tasks No ☐ Yes ☐ _____
Prefers being read to No ☐ Yes ☐ _____
Tilts head when reading No ☐ Yes ☐ _____
Tilts head when writing No ☐ Yes ☐ _____
Moves head when reading No ☐ Yes ☐ _____
Loses place while reading No ☐ Yes ☐ _____
Uses finger as a marker No ☐ Yes ☐ _____
Skips, rereads or omits words No ☐ Yes ☐ _____
Vocalizes when reading silently No ☐ Yes ☐ _____
Reads slowly No ☐ Yes ☐ _____
Poor reading comprehension No ☐ Yes ☐ _____
Comprehension decreases over time No ☐ Yes ☐ _____
Confuses letters or words No ☐ Yes ☐ _____
Reverses letters or words No ☐ Yes ☐ _____
Confuses right and left No ☐ Yes ☐ _____
Writes or prints poorly No ☐ Yes ☐ _____
Writes neatly but slowly No ☐ Yes ☐ _____
Tires easily No ☐ Yes ☐ _____
Difficulty copying from chalkboard No ☐ Yes ☐ _____
Remembers better what is heard than seen No ☐ Yes ☐ _____
Responds better orally than by writing No ☐ Yes ☐ _____
Seems to know material, but does poor on test No ☐ Yes ☐ _____
Slow to complete school work No ☐ Yes ☐ _____
Short attention span/ loses interest No ☐ Yes ☐ _____
Bumps into people / objects No ☐ Yes ☐ _____
Poor general coordination No ☐ Yes ☐ _____
Avoids (dislikes) sports No ☐ Yes ☐ _____
Difficulty catching / hitting a ball No ☐ Yes ☐ _____

Visual History

Has your child's vision been previously evaluated? No ☐ Yes ☐ Date of examination: _____
Doctor's Name: _____ Reason for exam: _____
Results and Recommendations: _____
Were glasses, contact lenses, or other optical devices recommended? No ☐ Yes ☐
If yes, what? _____
Are they used? No ☐ Yes ☐ If yes, when? _____
If not used, why not? _____
Member of the family who have had visual attention and the reason:

Name	Age	Visual Situation
_____	___	_____
_____	___	_____
_____	___	_____
_____	___	_____

Medical History

Pediatrician's Name: _____ Date of Last Evaluation: _____
Reason for last visit? _____
Results and recommendations: _____
_____
Current state of health: ❒ Good ❒ Fair ❒ Poor Other health problems_____
_____
List current Medications, including vitamins and supplements: _____
_____
For what condition(s)? _____
Is your child allergic to any medications? No ❒ Yes ❒ If yes, list: _____
Does patient use tobacco? ❒ No ❒ Yes: ___packs/day Alcohol? ❒ No ❒Yes (Some insurers require this question)
Immunizations child has received:
Immunization type: _____ Date: _____
Immunization type: _____ Date: _____
Immunization type: _____ Date: _____
Any reactions to immunization(s)? No ☐ Yes ☐ If yes, explain: _____
List any illnesses, traumatic/acquired brain injury, bad falls, high fevers, etc.:

Age	Description	Mild/Severe	Complications
_____			
_____			
_____			
_____			

Are there any chronic problems like ear infections, asthma, hay fever, allergies? No ☐ Yes ☐

If yes, please list: _____
Has your child been diagnosed on the autism spectrum? ❒ No ❒Yes ADHD? ❒ No ❒Yes

Has a neurological evaluation been performed? No ☐ Yes ☐ By whom: _____
Results and recommendations: _____
Has a psychological evaluation been performed? No ☐Yes ☐ By whom: _____
Results and recommendations: _____
Has an physical therapy evaluation been performed? No ☐ Yes ☐ By whom: _____
Results and recommendations: _____
Has an occupational therapy evaluation been performed? No ☐ Yes ☐ By whom: _____

Results and recommendations: _____

Has a speech/ language therapy evaluation been performed? No ☐ Yes ☐ By whom: _____
Results and recommendations: _____

Is there any history of the following? (Please check if it applies to the patient or a family member.)

	Patient	Relative / Parent / Sibling		Patient	Relative / Parent / Sibling
Diabetes	☐	☐ Who?_____	Cataracts	☐	☐ Who?_____
High Blood Pressure	☐	☐ Who?_____	Glaucoma	☐	☐ Who? _____
Thyroid Disease	☐	☐ Who?_____	Retinal Disease	☐	☐ Who?_____
Chromosomal Disorder	☐	☐ **Who?**_____	**Amblyopia**	☐	☐ **Who?**_____
Learning Disability	☐	☐ Who?_____	Strabismus/Eye turn	☐	☐ Who?_____

Review of Systems

Please circle all that currently apply to the patient only. If none apply (n/a), please check the box. **n/a**

Constitutional:	☐
Ears, Nose, Throat:	☐
Neurological:	☐
Hematological / Lymphatic:	☐
Musculoskeletal:	☐
Gastrointestinal:	☐
Psychiatric:	☐
Cardiovascular:	☐
Respiratory:	☐
Allergic / Immunologic:	☐
Endocrine:	☐
Skin / Breast:	☐
Genitourinary:	☐

Developmental History

Was child carried to a full term pregnancy? No ☐ Yes ☐ Normal birth? No ☐ Yes ☐
Did the mother experience any health problems during pregnancy? No ☐ Yes ☐
If yes, explain: _____
Any complications before, during, or immediately following delivery? No ☐ Yes ☐
If yes, explain: _____

Birth weight: _____ Apgar scores at birth: _____ After 10 minutes: _____
Were forceps used? No ☐ Yes ☐
Was there ever any reason for concern over your child's general growth or development? No ☐ Yes ☐
If yes, why? _____

Was your child an "easy" or "difficult" baby? _____ "Good" or "fussy"? _____
Any colic or early management problems? No ☐ Yes ☐ If yes, describe: _____
Was your child active in the crib? No ☐ Yes ☐ Is your child still active? No ☐ Yes ☐

Did your child crawl (on all fours)? No ☐ Yes ☐ At what age? _____
At what age would your child pull up on chairs and tables? _____
Did your child cruse (supporting self on furniture)? No ☐ Yes ☐ At what age? _____
If not, describe: _____
At what age did your child walk? _____

Speech: First words: _____ At what age: _____
Was early speech clear to others? No ☐ Yes ☐ Is speech clear now? No ☐ Yes ☐

Can your child dress himself? No ☐ Yes ☐ Button clothes? No ☐ Yes ☐ Tie bows? No ☐ Yes ☐
Zip zippers? No ☐ Yes ☐ Lace shoes? No ☐ Yes ☐

Could (s)he do these before entering school? No ☐ Yes ☐
Child's dominant hand (circle): right or left? Has guidance been given in use of hand? No ☐ Yes ☐

Leisure Time Activities/Television and Computer Viewing

Computer: Hours/day? _____ continuous or on/off Days/week? _____ Viewing Distance? _____
Video Games: Hours/day? ____ continuous or on/off Days/week? _____ Viewing Distance? _____
iPad/ tablet/ phone?___ _____ continuous or on/off Days/week? _____ Viewing Distance? _____
Television: Hours/day? _____ continuous or on/off Days/week? _____ Viewing Distance? _____
What programs does (s)he like the best? _____
What other activities occupy your child's leisure time? _____
Are there any activities your child would like to participate in, but doesn't? No ☐ Yes ☐
Please explain:

_____

_____

School

Name and Address of school: _____
Grade: ___ Teacher: _____ School nurse: _____ Principal: _____

Age at time of entrance to: Pre-school _____ Kindergarten _____ First Grade _____
Does your child like school? No ☐ Yes ☐
Specifically describe any school difficulties: _____

_____

Has your child changed schools often? No ☐ Yes ☐
If yes, when? _____
Has a grade been repeated? No ☐ Yes ☐
If yes, which and why? _____
Does your child seem to be under tension or pressure when doing school work? No ☐ Yes ☐
Has your child had any special tutoring, therapy, and/or remedial assistance? No ☐ Yes ☐
If yes, when? _____
Where and from whom? _____
How long? _____
Results: _____

Does your child like to read? No ☐ Yes ☐
Voluntarily ? No ☐ Yes ☐
Does your child read for pleasure? No ☐ Yes ☐
What type of material?_____

What is your child's attitude toward reading, school, his/her teachers, other youngsters?_____

_____

Overall schoolwork is: above average ☐ average ☐ below average ☐
Which Subjects are:
Above average: _____
Average: _____
Below average: _____
Does your child need to spend a lot of time/effort to maintain this level of performance? No ☐ Yes ☐

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? No ☐ Yes ☐

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

Are you concerned that these problems will interfere in advancing grades? No ☐ Yes ☐
If yes, please explain: _____

General Behavior

Are there any behavior problems at school? No ☐ Yes ☐
If yes, what? _____
Are there any behavior problems at home? No ☐ Yes ☐
What causes these problems? _____
How does the child get along with brothers and sisters? _____
Child's reaction to fatigue? Sag ☐ irritable ☐ other ☐ _____
Child's reaction to stress/ tension? Avoidance ☐ irritable ☐ other ☐ _____
Does the child respond to fatigue or tension by: Nail biting ☐ tantrums ☐ thumb sucking ☐ other _____
Does your child say and/or do things impulsively? No ☐ Yes ☐
Is your child in constant motion? No ☐ Yes ☐
Can your child sit still for long periods of time? No ☐ Yes ☐

Family and Home

Please indicate which adult(s) he/she lives with? Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Foster Parent ☐ Adoptive Parents ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ Other Caregiver ☐

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? No ☐ Yes ☐ If yes, at what age: _____
Does your child seem to have adjusted? No ☐ Yes ☐
Was counseling / therapy undertaken? No ☐ Yes ☐ If yes, is it on-going? No ☐ Yes ☐
Is family life stable at this time? No ☐ Yes ☐ If no, please explain: _____
How does your child get along with:
Parents / other caregivers? _____
Siblings? _____
Classmates in school? _____
Playmates at home? _____

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: _____

_____
_____
_____
_____
_____
_____
_____

Privacy Information

We want our patients to know that we have a privacy policy in place for your protection. You have the right to review our Notice of Privacy Policy. It is available at our reception desk for the asking.

I acknowledge that I have read (or been given the opportunity to read) the Notice. **Please initial here** _____

Release of information and insurance filing

It is often beneficial to us to discuss examination results and to exchange information with your child's school and/or other professionals involved in their care. Please sign below to authorize this exchange of information.

I agree to permit information from, or copies of, my child's examination records to be forwarded to my child's school, other health care providers or insurance carriers upon their written request or upon the recommendation of **Developmental Vision Care, P.C. / Kenneth R. Westcott, O.D**., when it is necessary for the treatment of my child's visual condition, or for processing insurance claims. By means of my signature below I authorize the exchange of information between my child's school(s) and other professionals involved in my child's care. This authorization shall be considered valid throughout the duration of treatment.

_____ _____
Signature Date

_____
Relationship to patient

I hereby give my permission to Developmental Vision Care, P.C. to treat _____.
(Child's name)

_____ _____
Parent's or Guardian's Signature Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation of your child and to better meet your child's specific visual needs.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us. You may leave a message for us 24 hours a day / 7 days a week. We require a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your examination so that we will have the maximum opportunity to evaluate your child's visual status.

Thank you.

Sincerely,

Kenneth R. Westcott, O.D.
Developmental Vision Care, P.C.

Would you like to receive notification of our free vision workshops? ❒ yes ❒ no

I am interested in the following topics:

❒ How Vision Affects Learning	❒ Classroom Accommodations	❒ ADHD: Unlocking the Mystery	❒ Kindergarten Readiness
❒ Reaching the Reluctant Reader	❒ Handwriting Help	❒ Remediation of letter Reversals	❒ Becoming a Super Speller

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