EyeCare Specialties
Center for Vision Development
2917 Pine Lake Road Suite B | Lincoln, NE 68512
(402) 323-2062 | eyecarespecialties.com

Extended Child Vision Questionnaire

Please fill this questionnaire out carefully and completely.

Appointment Date: ______________________________

Optometrist: ☐ Mikaela Betka, OD, FCOVD

General Information

Patient Full Name: ______________________________

☐ Male ☐ Female Birth Date: ______________ Age: ______________

Name of School: ______________________________ Grade: ______________

Were you referred to our office? ☐ Yes ☐ No

If yes, whom may we thank for this referral? Name: ______________________________

Is your child especially afraid of doctors? ______________________________

Family Information

Please list the names of your family:

Father/Guardian: ______________________________

Mother/Guardian: ______________________________

Sibling: ______________________________

Sibling: ______________________________

Sibling: ______________________________

Sibling: ______________________________

Responsible Party Information

Name of responsible party:____________________

Relationship to patient: ☐ Mother ☐ Father ☐ Guardian

Father's Employer:________________ Best Contact Phone:__________

Mother's Employer:________________ Best Contact Phone:__________

Guardian's Employer:________________ Best Contact Phone:__________

Medical History

Pediatrician's Name:________________ Date of last evaluation:__________

What prompted the last visit to the doctor?________________

Is your child under ongoing care for any medical conditions?________________

____

Medications currently using, including vitamins and supplements:________________

____

Has a neurological evaluation ever been performed? ☐ Yes ☐ No

By whom?________________ Results & Recommendations:________________

____

Is there any history of the following?

Diabetes	☐ Patient	☐ Family	Relationship__________
High Blood Pressure	☐ Patient	☐ Family	Relationship__________
Multiple Sclerosis	☐ Patient	☐ Family	Relationship__________
Epilepsy	☐ Patient	☐ Family	Relationship__________
Learning Disability	☐ Patient	☐ Family	Relationship__________
High Fevers	☐ Patient		
Ear Infections	☐ Patient		
Bad Fall and/or Concussion	☐ Patient		

Developmental History

Full-term pregnancy? ☐ Yes ☐ No

Did the mother experience any health problems during pregnancy? ☐ Yes ☐ No

If yes, explain:________________________________

Normal birth? ☐ Yes ☐ No Were forceps used? ☐ Yes ☐ No

Any complications before, during or immediately following delivery? ☐ Yes ☐ No

If yes, explain:________________________________

Birth weight:__________lbs __________oz

Was there ever any reason for concern over your
child's general growth or development? ☐ Yes ☐ No

If yes, why?________________________________

Did your child creep (stomach on floor) ☐ Yes ☐ No At what age?__________

Did your child crawl (on all fours)? ☐ Yes ☐ No At what age?__________

If not describe:________________________________

At what age did your child walk?________________________

Was your child active? ☐ Yes ☐ No

Speech: First words:____________________ At what age?__________

Was early speech clear to others? ☐ Yes ☐ No

Is speech clear now? ☐ Yes ☐ No

Has a speech therapy evaluation ever been performed? ☐ Yes ☐ No

If yes, by whom?________________________________

Has physical therapy ever been performed? ☐ Yes ☐ No

Has an occupational therapy evaluation ever been performed? ☐ Yes ☐ No

By whom?____________________Results & Recommendations:____________________

Visual History

Has your child's vision been previously evaluated? ☐ Yes ☐ No

If so, Doctor's name:____________________Date of last evaluation:____________________

Visual History (continued)

Reason for examination: ____________________

Results & Recommendations: ____________________

Were glasses, contact lenses, or other optical devices prescribed or recommended? ☐ Yes ☐ No

If yes, what? ____________________ Are they used? ☐ Yes ☐ No

If yes, when? ____________________ If not used, why? ____________________

Is there any history of the following?

Crossed or Wall Eye	☐ Patient	☐ Family	Relationship ____________
Amblyopia/Lazy Eye	☐ Patient	☐ Family	Relationship ____________
Glaucoma	☐ Patient	☐ Family	Relationship ____________
Other (Please explain below)	☐ Patient	☐ Family	Relationship ____________

Does your child report the following, or has anyone noticed the following:

Blur at distance	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Blur at near	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Headaches with near work	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Words run together or move on the page when reading	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Burning or watery eyes	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Eyes hurt/ache/fatigue with near work	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Falls asleep when reading	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Sees worse at the end of the day	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Skips/repeats lines	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Dizzy/nausea with near work	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Head tilt/closes one eye when reading	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Difficulty copying from board	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Avoids near work/reading	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Writes up/down hill	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Misaligns digits/columns of numbers	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always

Visual History (continued)

Does your child report the following, or has anyone noticed the following:

Reading comprehension down	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Poor/inconsistent in sports	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Holds reading too close	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Trouble keeping attention on reading	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Easily frustrated with near work/reading	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Poor eye/hand coordination (poor handwriting)	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Does not judge distance accurately	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Clumsy/knocks things over	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Car/motion sickness	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Forgetful/poor memory	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Eye turn	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Confuses left/right	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Confuses/reverses numbers, letters, or words	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Remembers better what he/she hears	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Prefers to be read to than to read him/herself	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always
Difficulty spacing between words when writing	☐ Never	☐ Seldom	☐ Occasionally	☐ Frequently	☐ Always

School

Age at time of entrance to: Preschool______________ Kindergarten______________

Does your child like school? ☐ Yes ☐ No Below, describe in detail any school difficulties:________

____

____

Has a grade been repeated? ☐ Yes ☐ No If yes, when & why?______________________________

____

School (continued)

Does your child seem to be under tension or extreme pressure when doing schoolwork? ☐ 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:____________________

Does your child like to read? ☐ Yes ☐ No

Does your child read for pleasure? ☐ Yes ☐ No

What is your child's attitude towards reading, school, his/her teachers?____________________

____

What subjects are:

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

Are there any behavior problems at school? ☐ Yes ☐ No

If yes, what?____

What causes these problems?____

Family and Home

Please indicate which adult(s) he/she lives with? ☐ Mother ☐ Father ☐ Stepmother

☐ Stepfather ☐ Foster Parents ☐ Adoptive Parents ☐ Grandmother ☐ Grandfather

☐ Aunt ☐ Uncle ☐ Other Caretaker (please specify):________________

Are there any behavior problems at home? ☐ Yes ☐ No

If yes, what?________________

What causes these problems?________________

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? ☐ Yes ☐ No If yes, at what age?________________

Does your child seem to have adjusted? ☐ Yes ☐ No

Was counseling/therapy undertaken? ☐ Yes ☐ No If yes, is it ongoing? ☐ Yes ☐ No

If no, please explain:________________

Is family life stable at this time? ☐ Yes ☐ No If no, please explain:________________

____

How does your child get along with:

Parents/other caretakers:________________

Siblings:________________

Playmates:________________

Give a brief description of your child as a person:________________

____

____

____

____

Is there any other information you feel would be helpful or important in our treatment of your child?

____

____

____

____

Release of Information

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 his/her 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 or other healthcare providers listed on the back of this release form or upon the recommendation of EyeCare Specialties, P.C. when it is necessary for the treatment of my child's visual condition. I authorize Dr. Betka and EyeCare Specialties, P.C. to exchange information with my child's school and other professionals involved in my child's care, by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

Signature Date

Relationship to patient

I hereby give my permission to EyeCare Specialties, P.C. to treat

Child's name

Parent or Guardian 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 child's appointment, please do not hesitate to contact us at 402-323-2062. You may leave a message for us after the clinic hours and on weekends. We will return your call as soon as possible the next business day. We request a minimum of 24 hours notice if you are unable to keep this appointment.

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

Sincerely,

Mikaela Betka, OD, FCOVD

Developmental Optometrist

EyeCare Specialties, P.C. is authorized to exchange and/or share information regarding the treatment of my child's visual condition to the following school and health care professionals:

Name:____________________
School or Business:____________________
Address:____________________
City:____________________State:__________Zip:__________

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School or Business:____________________
Address:____________________
City:____________________State:__________Zip:__________

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Address:____________________
City:____________________State:__________Zip:__________