Carl G. Hillier, OD, FCOVD ◆◆◆ Melissa C. Hillier, OD, FCOVD

Please fill out this questionnaire carefully. Please return it to our office prior to your appointment.

Appointment: Day ____________________ Date ____________________ Time ____________________

Patient's Name: ____

GENERAL INFORMATION

Were you referred? Yes _____ No _____

If yes, by whom? ______________________________ Phone: ____________________

Address: ____

Child's Full Name: ______________________________ Male _____ Female _____

Birth Date: ____________________ Age: _____ years _____ months

Name and address of school: ______________________________

Grade ____ Teacher ____________ School Nurse ____________ Principal ____________

Is your child especially afraid of doctors? Yes or No (please circle)

Child's handedness: Right or Left (please circle)

HOME: Father/Guardian ____________________ Birth Date ____________________

Mother/Guardian ____________________ Birth Date ____________________

Siblings ____________________ Birth Date ____________________

____________________ Birth Date ____________________

____________________ Birth Date ____________________

PARENT INFORMATION

Please Circle: ***Mother Father Both Other*** ______________________________

Home Address ____________________ City ____________ Zip________

Home Phone ____________________ Cell Phone ____________________

Business Address ____________________ City ____________ Zip________

Business Phone ____________________ Email Address ____________________

Please Circle: ***Mother Father Both Other*** ______________________________

Home Address ____________________ City ____________ Zip________

Home Phone ____________________ Cell Phone ____________________

Business Address ____________________ City ____________ Zip________

Business Phone ____________________ Email Address ____________________

Do you have Major Medical Insurance? ____________ Insured ____________________

Social Security Number ____________________ Driver's License No. ____________

7898 Broadway, Lemon Grove, CA 91945 ◆ Telephone (619) 464-7713 ◆ Fax (619) 464-7668
336 Encinitas Blvd., #140, Encinitas, CA 92024 ◆ Telephone (760) 479-2518 ◆ Fax (619) 464-7668
Email address: vtherapy@pacbell.net

MEDICAL HISTORY

Physician's Name ______________________ Date of Last Visit ______________

Results ____

Medications currently using ______________________________________

For what condition? ______________________________________

Any history in your family of the following:

Diabetes ....Yes ______ No ______

Glaucoma ....Yes ______ No ______

High blood pressure ....Yes ______ No ______

Macular Degeneration ....Yes ______ No ______

List illnesses, bad falls, high fevers, ear infections, head injuries, eye injuries, etc.:

Age	Severe	Mild	Complications

Is your child generally healthy? ....Yes ______ No ______

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

If yes, please list ______________________________________

Has a speech / language evaluation been performed? ....Yes ______ No ______

By whom? ______________________ When? ______________________

Results ____

Has an occupational therapy evaluation been performed? ....Yes ______ No ______

By whom? ______________________ When? ______________________

Results ____

Has a neurological evaluation been performed? ....Yes ______ No ______

By whom? ______________________ When? ______________________

Results ____

Has a psychological evaluation been performed?.......................................Yes ______ No ______

By whom? ______________________ When? ______________________

Results ____

NUTRITIONAL INFORMATION

Current Diet: Excellent ________ Good ________ Fair ________ Poor ________

Does your child:

like sweets ....Yes ______ No ______

crave sweets ....Yes ______ No ______

Is your child active? ....Yes ______ No ______

moderately? ....Yes ______ No ______

extremely? ....Yes ______ No ______

Are there periods of very high energy? ....Yes ______ No ______

very low energy?..Yes ______ No ______

DEVELOPMENTAL HISTORY

Full-term pregnancy? ....Yes ______ No ______

Normal birth? ....Yes ______ No ______

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

Did your child crawl (stomach on floor)? Yes ______ No ______ At What Age? _______________

Did your child creep (stomach off floor)? Yes ______ No ______ At What Age? _______________

All fours?....................................... Yes ______ No ______

If not, describe ____

At what age did your child walk? ____________________ Was your child active? Yes ______ No ______

Speech: First words at age ________

Was early speech clear to others? Yes ______ No ______ Is it clear now?..........Yes ______ No ______

VISUAL HISTORY

Doctor's Name ___________________________________ Date of Last Visit ___________________________

Reason for examination:____

Results ____

Were glasses prescribed? Yes ______ No ______ Are they worn? ....Yes ______ No ______

If yes, when are they worn?____

Was Vision Therapy prescribed...Yes ______ No ______

Was Vision Therapy done?...Yes ______ No ______

If yes, for how long? ____

Members of the family who have had visual attention and the reason:

Name	Age	Visual Situation
_______________________	______	____
_______________________	______	____

PRESENT SITUATION

Is there any evidence from the school, psychological, pediatric, occupational therapy, or speech/language tests that indicate some visual malfunction may be present? Yes ______ No _______

If yes, what? ____

____

____

Does your child report any of the following:	Yes	No	If yes, when?
Headaches	_____	_____	____________________________
Blurred vision	_____	_____	____________________________
Double vision	_____	_____	____________________________
Eyes "hurt" or tired"	_____	_____	____________________________
Words move around on the page	_____	_____	____________________________
Motion sickness	_____	_____	____________________________

List any other complaints your child makes concerning his/her vision:

____

HAVE YOU EVER NOTICED THE FOLLOWING:

	Yes	No	If yes, when?
Eyes frequently reddened	_____	_____	______________________________
Frequent eye rubbing	_____	_____	______________________________
Frequent blinking	_____	_____	______________________________
Closing or covering one eye	_____	_____	______________________________
Head close to paper when reading or writing	_____	_____	______________________________
Tilting head when reading or writing	_____	_____	______________________________
Moving head when reading	_____	_____	______________________________
Confusing letters or words (circle one or both)	_____	_____	______________________________
Reversing letters or words (circle one or both)	_____	_____	______________________________
Skipping, rereading and omitting words	_____	_____	______________________________
Losing place while reading	_____	_____	______________________________
Vocalizing when reading silently	_____	_____	______________________________
Reading slowly	_____	_____	______________________________
Using finger as a marker	_____	_____	______________________________
Poor reading comprehension	_____	_____	______________________________
Poor spelling	_____	_____	______________________________
Writing or printing poorly	_____	_____	______________________________
Tiring easily	_____	_____	______________________________
Difficulty completing assignments	_____	_____	______________________________
Avoids activities that are within arms reach	_____	_____	______________________________
Shortened attention span for reading or writing	_____	_____	______________________________
Poor motor coordination	_____	_____	______________________________
Difficulty catching or hitting a ball	_____	_____	______________________________
Difficulty copying from the board at school	_____	_____	______________________________

"SCREEN TIME"

Academic Computer time: Days per week_______ Hours per day____ Distance from eyes to screen_____

Computer/TV Video Games: Days per week_______ Hours per day____ Distance from eyes to screen_____

Hand held video games: Days per week_______ Hours per day____ Distance from eyes to screen_____

Television: Days per week_______ Hours per day____ Distance from eyes to screen_____

SCHOOL

Age at time of entrance to: Kindergarten ____________________ First Grade ________________________

Does your child like school?..Yes _____ No _____

Has your child changed schools often?..Yes _____ No _____

If yes, when? ____________________________________

Has a grade been repeated?.. ....Yes _____

No _____

If yes, which?____________________________________

Does your child seem to be under tension or extreme pressure when doing schoolwork?.Yes ____ No _____

Does your child avoid homework?.. Yes ____ No _____

Does your child take too long to do homework? ....Yes _____ No _____

Has your child had any special tutoring and/or remedial assistance? ....Yes _____ No _____

If yes, when? ______________________________

From whom? ______________________________

Where? ______________________________

How long? ______________________________

Result: ______________________________

What school subjects are easy for your child? ______________________________

What school subjects are difficult for your child? ______________________________

Does your child like to read? Yes _____ No _____ Does your child like to be read to? Yes ______ No ______

Voluntarily? Yes ______ No ______ What? ______________________________

Specifically describe any school difficulties: ______________________________

____

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

____

Does your child have an I.E.P.? Yes ______ No ______ A 504 Plan? Yes ______ No ______

An Advocate? Yes ______ No ______ Who? ______________________________

School work is: Above average ______ Average ______ Below average ______

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 ______

GENERAL BEHAVIOR

Are there any behavior problems at school?..Yes ______ No ______

Are there any behavior problems at home?...Yes ______. No ______

What causes these problems? ______________________________

Your child's reaction to fatigue? sag _____ irritable _____ other ______________

Your child's reaction to tension? nail-biting _____ thumb-sucking _____ other ______________

Does your child say and/or do things impulsively?.......................................Yes ______ .No ______

Is your child in constant motion? ....Yes ______ .No ______

Can your child sit still for long periods? ....Yes ______ .No ______

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 ______________________________

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? .... Yes ______ No______

What age was (s)he? ____________________

Does your child seem to have adjusted?..Yes ______ No.______

Is family life stable at this time? ....Yes ______ No.______

How does your child get along with:

Parents? ____________________

Siblings? ____________________

Classmates in school? ____________________

Playmates at home? ____________________

Did his/her father or anyone in father's family have a learning problem?...........Yes ______ No ______

Who? ____________________

Did his/her mother or anyone in mother's family have a learning problem? ....Yes ______ No ______

Who? ____________________

Do any other children in the family have learning problems? ....Yes ______ No ______

Who? ____________________

To what extent? ____________________

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

RELEASE OF INFORMATION AND INSURANCE FILING

I agree to permit information from, or copies of, my child's examination records to be forwarded to other health care providers or insurance carriers upon their written request or upon the recommendation of the San Diego Center for Vision Care – Optometry, P.C. when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I release payment of benefits to myself or to the San Diego Center for Vision Care – Optometry, P.C.

If records or reports are requested by my child's school district, I authorize their release.

____________________ ____________________

Signature Date

I hereby give my permission to the San Diego Center for Vision Care – Optometry, 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 relate the current visual skills to any specific needs. Please be on time for your examination.

Thank you,

The Doctors and Staff
San Diego Center for Vision Care - Optometry, P.C.