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

TODDLER/PRESCHOOL VISION QUESTIONNAIRE

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

Child's handedness: right or left? _______________________________________

Home: Father/Guardian ______________________________ Birth Date _______________________

Mother/Guardian ______________________________ Birth Date _______________________

Sibling(s) ______________________________ Birth Date _______________________

______________________________ Birth Date _______________________

______________________________ Birth Date _______________________

______________________________ Birth Date _______________________

PARENT INFORMATION

Home Address _______________________________________ City _______________ Zip ___________

Home Phone ________________________

Father's Occupation _________________________________ Business Phone ______________________

Business Address ____________________________________ City ________________ Zip ___________

Mother's Occupation _________________________________ Business Phone ______________________

Business Address ____________________________________ City ________________ Zip ___________

Do you have Major Medical Insurance? _________________

If so, who is the carrier?______________________________ Policy # ___________________________

Name of Insured _____________________________________ Do you have a flex spending account? Y N

Social Security Number ______________________________ Driver's License______________________

MEDICAL HISTORY

Physician's Name ______________________________________ Date of Last Visit __________________

Results: ____

Please continue on the other side

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MEDICAL HISTORY (continued)

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 ______

List illnesses, bad falls, high fevers, 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 neurological evaluation been performed? .... Yes ______ No ______

By whom? ______________________ Results ______________________

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

By whom? ______________________ Results ______________________

NUTRITIONAL INFORMATION

Current Diet: Excellent ________ Good ________ Fair ________ Poor ________

Does your child

like sweets.................... Yes ______ No ______

crave sweets.................... Yes ______ No ______

Are there periods of

very high energy? .... Yes ______ No ______

very low energy?.................... Yes ______ No ______

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

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

Can your child sit for long periods of time?.................... 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 ______

Age ______________

Did your child creep (stomach off floor)? .... Yes ______ No ______

Age ______________________

At what age did your child walk?______________________________

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

If yes, was his/her activity level low, moderate or high? ______________________

Speech: First words at age __________________

Was early speech clear to others?.................... Yes ______ No ______

Is it clear now? .... Yes ______ No ______

TELEVISION VIEWING

How much? __________________ How often? __________________ Viewing distance ______________

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 patching or eye surgery ever recommend? ....Yes ______ No ______

Was vision therapy prescribed? ....Yes ______ No ______

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

Name	Age	Visual Situation
____________________	______	______________________________________
____________________	______	______________________________________

PRESENT SITUATION

Why do you feel your child needs a visual assessment? ___________________________________

____

Is there any evidence from the preschool or psychological tests that indicates 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"	_____	_____	______________________

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	_____	_____	______________________
Closes or covers one eye	_____	_____	______________________
Difficulty with drawing	_____	_____	______________________
Head close to paper when reading or writing	_____	_____	______________________
Tilts head when drawing	_____	_____	______________________
Difficulty coloring within lines	_____	_____	______________________
Difficulty learning letters	_____	_____	______________________
Tires easily with near tasks	_____	_____	______________________
Avoids near tasks	_____	_____	______________________
Short attention span	_____	_____	______________________
Poor motor coordination	_____	_____	______________________
Difficulty catching or hitting a ball	_____	_____	______________________
Motion sickness	_____	_____	______________________

If your child attends preschool, please fill out the following:
Name of Preschool ____
Teacher ______________________ Director ______________________
Age at time of entrance to preschool ________
Does your child like preschool? ....Yes _____ No _____
Does your child like the teacher?..Yes _____ No _____
Activities performed are: 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 _____
Which school activities are easy for your child?___________________________
____
Which school activities are difficult for your child? _______________________
____
Can your child identify letters?...................................Yes _____ No _____ Some _____
Does your child like to look at books? ....Yes _____ No _____
Does your child like to be read to? ....Yes _____ No _____
Is your child learning to read?..Yes _____ No _____

If yes, how is your child doing? ____________________________________

Does your child like to draw? ....Yes _____ No _____
Specifically describe any school difficulties: ______________________________
____
Are there any behavior problems at school? ....Yes _____ No _____
Are there any behavior problems at home?..Yes _____ No _____
What causes these problems? ______________________________________
Has your child had any special help and/or remedial assistance? ....Yes _____ No _____

If yes, why? ____
When? ____
From whom? ____
For how long? ____
Result: ____

What is your child's attitude toward reading, school, his/her teachers, other youngsters? ________
____
____
How well developed is your child's spoken vocabulary?_______________________

FAMILY AND HOME

Please indicate which adult 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? ___________________________________

FAMILY AND HOME (continued)

Does/did the father or anyone in the father's family have a learning problem? ..Yes ______ No ______
If yes, who? ____
Does/did the mother or anyone in the mother's family have a learning problem?Yes ______ No ______
If yes, who? ____
Do any, or did any, of the other children in the family have learning problems?..Yes ______ No ______
If yes, who? ____
To what extent? ____
How many hours per week does your child watch T.V.?___________
How many hours per week does your child use a computer?___________

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

If needed in the future, 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 authorize the San Diego Center for Vision Care – Optometry, P.C. to obtain clinical reports regarding the care of my child.

____ _______________________________

Parent's or Guardian's 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 screening evaluation of your child's visual system to your child's specific needs.

Please be on time for your examination.

Thank you.

The Doctors And Staff
San Diego Center for Vision Care – Optometry, P.C.