Owl Optometry
173 Roncesvalles Ave, Toronto, Ontario M6R 2L3
647-349-2020

CHILDRENS VISION QUESTIONNAIRE – EXTENDED

*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 to our office? Yes □ No □
If yes whom may we thank for the referral? _____ Phone: _____
Child's full name: _____
Male □ Female □
Birth Date: _____Age: _____Years: _____Months: _____
Name and address of School: _____
_____
Grade: _____ Teacher: _____
Is your child especially afraid of doctors? _____
Child's dominant hand? _____ Has guidance been given in use of hand? _____

RESPONSIBLE PERSON INFORMATION

Home address: _____ City: _____
Home phone: _____
Mother/caretaker's Occupation: _____

MEDICAL HISTORY

Pediatrician's name: _____Date of last Evaluation: _____
For what reason? _____
Results and recommendations: _____
_____

Child's current state of health: _____
_____
Current medications, including vitamins and supplements: _____
_____
_____
For what conditions? _____
_____
_____
Immunization's child has received:
Immunization type:_____ Up to date? Yes □ No □
Immunization type:_____ Up to date? Yes □ No □
Immunization type:_____ Up to date? Yes □ No □
Immunization type:_____ Up to date? Yes □ No □

Any reactions to immunization(s)? Yes □ No □ If yes, explain:_____
_____
_____

List any illness, bad falls, high fevers, etc.

Age: _____ Severe □ Mild □
Complications: _____
_____
Age: _____ Severe □ Mild □
Complications: _____
_____
Age: _____ Severe □ Mild □
Complications: _____
_____

Is your child generally healthy? Y □ N □
If no, explain:
_____
_____

Are there any chronic problems like ear infections, asthma, hay fever, allergies? Y/N
If yes, please list: _____
_____
_____

Has a neurological evaluation been performed? Y □ N □ By Whom? _____
Results/recommendations:_____
_____

Has an occupational therapy evaluation been performed? Yes □ No □ By whom? _____
Results and recommendations: _____
_____

Is there any history of the following? (Please check if there is a history)

	Patient	Family	Who
Diabetes			
"Cross" or "Wall" eye	☐	☐	_____
Chromosomal Imbalance	☐	☐	_____
Glaucoma	☐	☐	_____
High blood pressure	☐	☐	_____

Learning disability	☐	☐	_____
Amblyopia (lazy eye)	☐	☐	_____
Multiple Sclerosis	☐	☐	_____
Epilepsy/seizures	☐	☐	_____

Other (please explain)

_____

NUTRITIONAL INFORMATION

Current diet: Excellent □ Good □ Fair □

Does your child: Like sweets □ **OR** crave sweets □

If yes, what types?_____

Is your child active? Yes ☐ No ☐

Moderately? Yes ☐ No ☐

Extremely? Yes ☐ No ☐

Are there periods of

Very high energy? Yes ☐

Very low energy? Yes ☐

Explain:

DEVELOPEMENTAL HISTORY

Full term pregnancy? Yes ☐ No ☐

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

If yes explain:

_____

_____

Normal birth? Yes ☐ No ☐

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

If yes explain: _____

_____

Birth weight: _____Apgar scores at birth: _____After 10 minutes: _____

Were forceps used? Yes ☐ No ☐

Was there ever any reason for concern over your child's general growth or development?

Yes ☐ No ☐ If yes why? _____

_____

Did your child crawl (stomach or floor)? Yes ☐ No ☐ At what age? _____

Did your child creep (on all fours)? Yes □ No □

If not, describe: _____

_____

At what age did your child walk?

Was the child active? Yes □ No □

Speech -First words:_____

Was early speech clear to others? Yes □ No □
Is speech clear now? Yes □ No □

VISUAL HISTORY (If current patient of Owl Optometry skip to next question)
Has your child's vision been previously evaluated? Yes No
If so, Doctor's name: _____ Date of last evaluation:_____
Reason for examination:_____
Results and recommendations: _____
Were glasses, contact lenses or other optical devices recommended? Yes □ No □
If yes, what? _____
Are they used? Yes No If yes, when? _____
If not used why not? _____

PRESENT SITUATION
Why do you feel your child needs a visual evaluation? _____
How long has this problem/difficulty been observed? _____

Is there any evidence from the school, psychiatrist or other 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/focus goes in and out	□	□	_____
Double vision	□	□	_____
Eyes hurt	□	□	_____
Eyes tired	□	□	_____
Words move around on page	□	□	_____
Motion sickness/car sickness	□	□	_____
Dizziness			

List any other complaints your child makes concerning their vision _____
_____

Have you or anyone else ever noticed the following:

	Yes	No	If yes, when?
Eyes frequently reddened	□	□	_____
Frequent eye rubbing	□	□	_____
Frequent sties	□	□	_____
Frowning	□	□	_____
Bothered by light	□	□	_____
Frequent blinking	□	□	_____
Closing or covering one eye	□	□	_____
Difficulty seeing distant objects	□	□	_____
Head close to paper when reading or writing	□	□	_____
Avoids reading	□	□	_____
Prefers being read to	□	□	_____

Tilts head when reading	□	□	_____
Tilts head when writing	□	□	_____
Moves head when reading	□	□	_____
Confuses letter or words	□	□	_____
Reverses letter or words	□	□	_____
Confuses right and left	□	□	_____
Skips,rereads or omits words	□	□	_____
Loses place while reading	□	□	_____
Vocalizes when reading silently	□	□	_____
Reads slowly	□	□	_____
Uses finger as a marker	□	□	_____
Poor reading comprehension	□	□	_____
Comprehension decreases over time	□	□	_____
Writes or prints poorly	□	□	_____
Writes neatly but slowly	□	□	_____
Does not support paper when writing	□	□	_____
Awkward or immature pencil grip	□	□	_____
Tires easily	□	□	_____
Difficulty copying from chalkboard	□	□	_____
Any history of concussion	□	□	_____
Difficulty recognizing same word on different page	□	□	_____
Poor word attack skills	□	□	_____
Difficulty with memory	□	□	_____
Remembers better what hears than sees	□	□	_____
Responds orally than by writing	□	□	_____
Seems to know material but does poorly on tests	□	□	_____
Dislikes/avoids near tasks	□	□	_____
Short attention span/looses interest	□	□	_____
Poor large motor coordination	□	□	_____
Poor fine motor coordination	□	□	_____
Difficulty with scissors/small hand tools	□	□	_____
Dislikes/avoids sports	□	□	_____
Difficulty catching/hitting a ball	□	□	_____

TELEVISION/LEISURE TIME ACTIVITIES

Does child watch TV? _____ How much? _____ How often? _____ Viewing distance? _____
Does your child spend time using computer/video games? _____ How much? _____
How often? _____ Viewing distance _____
What other activities occupy your child's leisure time? _____
Are there any activities your child would like to participate in but doesn't? _____
Please explain_____
_____

SCHOOL

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

Has your child changed schools? Yes □ No □
If yes, when? _____
Has a grade been repeated? Yes □ No □ If yes, which and when? _____
Does your child seem to be under tension or extreme pressure when doing schoolwork? Yes □ No □
Has your child had any special tutoring or remedial assistance? Yes □ No □
If yes when? _____
Where and from whom? _____
How long? _____
Results? _____
_____
Does your child like to read? Yes □ No □ Voluntarily? Yes □ No □
Does your child read for pleasure? Yes □ No □
What? _____
What is your child's attitude toward reading, school, their teachers, other children? _____
_____
_____
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? _____
How much time on average does your child spend each day on homework? _____
To what extent do you assist your child with homework? _____
Do you feel your child is achieving up to their potential? _____
Does your child feel they are achieving up to potential? _____

GENERAL BEHAVIOUR

Are there any behavioral problems at school? _____
_____
Are there any behavioral problems at home? _____
_____
What causes these problems? _____
Child's reaction to fatigue? _____
Child's reaction to tension? Avoidance □ irritable □ Other □
Does your child say/do things impulsively? Yes □ No □
Is your child in constant motion? Yes □ No □
Can your child sit still for long periods of time? Yes □ No □

FAMILY AND HOME

Please indicate which adult(s) the child lives with: Mother □ Father □ Other □
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? _____
If yes, please elaborate: _____
_____
Does your child seem to have adjusted? Yes □ No □
Was counselling/therapy undertaken? Yes □ No □
If yes, is it still going on? Yes □ No □

Is family life stable currently? Yes □ No □
If no, please elaborate _____
_____
How does your child get along with?
Parents/other caretakers? _____
Siblings? _____
Classmates in school? _____
Playmates at home? _____
Did the father or anyone in the father's family have any learning problems? Yes □ No □
If yes, who? _____
Did the mother or anyone in the mother's family have a learning problem? Yes □ No □
If yes, who? _____

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?
_____
_____
_____
_____
_____