The Center for Vision Development

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Thank you for carefully completing this questionnaire, to personalize your child's care.
Please return all forms at least 24 hours prior to your appointment by fax, email or regular mail.

Patient's Name:____Nickname:______________________________
Date of Birth:__________ Age Now:__________ Gender: Male ☐ Female ☐
Were you referred to us? Yes ☐ No ☐
If you were referred, whom may we thank?____
Referral Type: Doctor ☐ Therapist ☐ Family ☐ Friend ☐ Other:________________
If not referred, how did you hear about us?____

YOUR CHILD'S CONTACT INFORMATION
Home Address:____
City:______________________ State:_______ Zip:_________ Home Phone:______________________________
Mother/Caretaker's Name:____________________________________Email:______________________________
Occupation:______________________Business Phone:______________________Cell Phone:_________________
Father/Caretaker's Name:_____________________________________Email:______________________________
Occupation:______________________Business Phone:______________________Cell Phone:_________________
Preferred Contact:____
Preferred Method of Contact: Home Phone ☐ Business Phone ☐ Cell Phone ☐ Email ☐

YOUR CHILD'S MEDICAL HISTORY
Pediatrician's Name:________________________________ Is your child especially afraid of doctors? Yes ☐ No ☐
Last Visit Date:____________ For what reason?______________ Is your child generally healthy? Yes ☐ No ☐
Medications (include vitamins/supplements):____
____
Does your child receive immunizations? Yes ☐ No ☐

Please indicate if your child has problems with any of the below.

Event/Condition	Yes/No	Please describe, including time of onset
Constitutional symptoms (e.g. fever, weight loss)		
Hematologic (e.g. anemia)		
Allergic/immunologic		
Endocrine		
Psychiatric		
Neurological		
Cardiovascular		
Respiratory		
Ears, nose, mouth or throat		
Gastrointestinal		
Skin disorders		
Muscoloskeletal		
Genitourinary		

YOUR CHILD'S FAMILY HISTORY (Please check if there is any history of the following.)

	Patient	Family	If Family, Who?		Patient	Family	If Family, Who?
Poor Vision/Hi Rx				Diabetes			
Strabismus/ eye turn				High Blood Pressure			
Amblyopia (lazy eye)				Epilepsy or Seizures			
Glaucoma				Learning Issue			
Blindness				Other			

YOUR CHILD'S VISUAL HISTORY:

Has your child's vision been previously evaluated? Yes ☐ No ☐ If "Yes," Doctor's Name:_______________

Date of Evaluation:_______________ Results and recommendations:_______________

Does your child wear: Glasses ☐ Contacts ☐ Both ☐ Worn for which activities?_______________

Please describe any other visual symptoms that you notice:_______________

____

Does your child verbalize any problems/complaints about his/her eyes or vision? Yes ☐ No ☐

If "Yes," explain:_______________

Do you notice any of the following in your child?

☐ An eye turns in or out (SEE ADDENDUM)
☐ Reddened or encrusted eyes
☐ Eyes in constant motion
☐ Eyelids droop
☐ Stares at bright lights or repeatedly flicks objects in front of face
☐ Excessive watering of eyes or eye rubbing
☐ Is abnormally bothered by bright lights
☐ Seems visually aware
☐ Turns head to use one eye only
☐ Moves objects very close to look at them
☐ Squints while looking at objects
☐ Blinks excessively
☐ Has a tendency to rub eyes
☐ Covers or closes one eye
☐ Stumbles over objects or is clumsy
☐ Poor motor control
☐ Lacks interest in looking at objects or seeing
☐ Unable to see distant objects
☐ Unable to transfer object from hand to hand or pass objects across the midline of body
☐ Is unable to stack blocks or other objects

YOUR CHILD'S DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes ☐ No ☐ How premature? _______________ Vaginal delivery ☐ C Section Delivery ☐

Were there any health problems during the pregnancy/delivery for mother/child? Yes ☐ No ☐

If "Yes," explain:_______________

Birth weight:_______________ Apgar scores @ birth:________ After 10 minutes:_____

Were there any difficulties at all in feeding (such as difficulty with sucking, vomiting?) Yes ☐ No ☐

If "Yes," explain:_______________

Any problems with colic? Yes ☐ No ☐

Has there been any concern over your child's general growth or development? Yes ☐ No ☐

If "Yes," explain:_______________

Has your child received any special developmental guidance/ assistance? Yes ☐ No ☐

If "Yes," explain:_______________

How many hours daily does your child sleep? ____ Does your child sleep through the night? Yes ☐ No ☐
If "Yes," starting at what age: ______ If "No," explain:______________________________

What percent of the waking hours is/was your child in a: playpen? ____ walker? ____ seat? ____
What things can your child do very well? ______________________________
What things, if any, are difficult for your child? ______________________________

Have any of the following evaluations been performed?
Neurological evaluation? Yes ☐ No ☐ By whom?______________________________
Results and recommendations:______________________________
Psychological evaluation? Yes ☐ No ☐ By whom?______________________________
Results and recommendations:______________________________
Occupational therapy evaluation? Yes ☐ No ☐ By whom?______________________________
Results and recommendations:______________________________
Speech therapy evaluation? Yes ☐ No ☐ By whom?______________________________
Results and recommendations:______________________________

YOUR CHILD'S NUTRITIONAL INFORMATION
Current Diet: Nursed ☐ or nursed until what age? _____ Bottle fed ☐ Solid food ☐
Solid food started at what age? ______ What foods? ______________________________
Has your child tested positive for food allergies or sensitivities? Yes ☐ No ☐ If so, which foods?
____
Any foods your child especially likes? ______________________________
Any foods your child especially dislikes? ______________________________

PRE-SCHOOL (If your child attends preschool, please answer these questions.)
School Name:______________________________
Teacher Name:______________________ Director Name:______________________
Age at time of entrance to pre-school: _______ Does your child like pre-school? Yes ☐ No ☐
How does your child's general performance and social skills compare to others of same age? ______________
Which pre-school activities are easy for your child? ______________________________
Which pre- school activities are difficult for your child? ______________________________
Specifically describe any pre-school / day care concerns / difficulties: ______________________________
____
Does your child seem to be under tension at pre-school/day care? Yes ☐ No ☐
If "Yes," explain:______________________________

CURRENT ABILITIES/BEHAVIOR

If known, list the age at which your child could do the following: (some of these behaviors may not apply to your child).

Activity	Age	Activity	Age
Responsive smile		Stack blocks	
Crawl (stomach on floor)		Walk alone	
Roll over		Scribble spontaneously	
Creep (stomach off floor)		Kick a ball	
Sit up alone		Walk up steps with help	
Respond to words and names		Use two-word sentences	
Say single words		Become toiled-trained	
Give first name		Put on some clothing alone	

Can your child identify colors? Yes ☐ No ☐ If "Yes," which? ______________________________
Can your child identify numbers or letters? Yes ☐ No ☐ If "Yes," which? ______________________________
Does your child like to draw/color? Yes ☐ No ☐
Is your child learning to read? Yes ☐ No ☐

How is your child performing as compared to others his/her age: Above average ☐ Average ☐ Below average ☐
How well developed is your child's spoken vocabulary? ______________________________
How well does your child understand/respond to spoken language? ______________________________

Check the appropriate spaces if you have any concerns about the following behavior(s) in your child:

☐ Lack of curiosity	☐ Hyperactive, high energy	☐ Has difficulty separating from parents
☐ Thumb-sucking	☐ Passive	☐ Sleeplessness
☐ Nervous	☐ Irritable, easily upset	☐ Lethargic, low energy
☐ Glum, sulky, moody	☐ Restlessness	☐ Aggressive

☐ Other (please explain): ______________________________

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:______________________________
____
____
____

WHAT ARE YOUR BIGGEST CONCERNS REGARDING YOUR CHILD AT THIS TIME?______________________________
____
____
____

WHAT IS YOUR GOAL FOR YOUR CHILD'S VISUAL EVALUATION AND/OR TREATMENT?______________________________
____
____
____

If you have any questions or concerns that we may answer prior to your appointment, please contact us.

We are looking forward to meeting you!

Sincerely,

Christina M. Danley, O.D.
Developmental Optometrist

Developmental Optometrists specialize in the testing and training of visual skills needed for proper development and school readiness.

STRABISMUS/AMBLYOPIA ADDENDUM

(Please complete if applicable)

Have you ever been told that your child has amblyopia ("lazy eye")? Yes ☐ No ☐ If "Yes," at what age?______________
Have you ever been told that your child has strabismus ("eye turn")? Yes ☐ No ☐ If "Yes," at what age?_____________
Have your child had an eye surgery? Yes ☐ No ☐ If "Yes," please describe the surgery, including the age surgery was performed, the number of operations, the eye(s) operated on:____
____
Was the surgeon satisfied with the results of surgery? Yes ☐ No ☐ Explain:____
Were you satisfied with the results of surgery? Yes ☐ No ☐ Explain:____
Have surgical results been maintained? Yes ☐ No ☐ Explain:____
Are you here for a second opinion regarding surgery or other treatment? Yes ☐ No ☐

IF YOUR CHILD'S EYE TURNS:

- At what age did you first notice or suspect that was an eye turning?____
- Did it begin turning: suddenly ☐ or gradually ☐ ? Explain:____
  (Note: A sudden eye turn may be due a serious medical emergency and requires immediate medical attention.)
- Does the eye turn: in ☐ out ☐ up ☐ or down ☐ ? (check all that apply)
- Is the eye turn getting: worse ☐ or better ☐ or is there no change ☐ ?
- Is it always the same eye that turns? Yes ☐ No ☐ If "Yes," which eye? Right ☐ Left ☐
- Is the eye turn always present? Yes ☐ No ☐
  - If no, under what conditions is it present? ____
- Does the eye always turn the same amount? Yes ☐ No ☐
  - If no, explain: ____
- Do you notice if the eye turns more when your child is looking:
  - up close? Yes ☐ No ☐
  - in the distance? Yes ☐ No ☐
  - to the left? Yes ☐ No ☐
  - to the right? Yes ☐ No ☐
  - up? Yes ☐ No ☐
  - down? Yes ☐ No ☐

Does the eye turn less (or vision improve) when the prescription is worn? Yes ☐ No ☐ Unsure ☐
Has your child ever used an eye patch? Yes ☐ No ☐
If "Yes," please describe your child's age when the patching was started, how the patching was done and for how long, the eye patched, and an estimate of the results: ____
____
Does one pupil ever appear to be larger than the other? Yes ☐ No ☐
Do you ever notice one or both eyes shaking rapidly? Yes ☐ No ☐
What is your child's best corrected vision, if known?____
What are your biggest concerns regarding your child's strabismus or amblyopia?_________________________________
____
____

Release of Information

IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH OTHER PROFESSIONALS INVOLVED IN YOUR CHILD'S CARE, *WITH YOUR PERMISSION*. 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 other health care providers upon their written request or upon the recommendation of the The Center for Vision Development when it is necessary for the treatment of my child's visual condition. I authorize Dr. Christina Danley and The Center for Vision Development to exchange information with 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 The Center for Vision Development to treat ____________________________________.
Child's Name

______________________________________ ____________________
Parent's or Guardian's Signature Date