the eyeclinic
Doctors + Vision Therapy

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Child Patient Information (0 to 4 year old)

Please fill out this questionnaire carefully and return it to our office 1 week prior to your appointment. The time spent answering the questions will allow the doctor to better plan the flow of the examination procedures. Leave blank or put " N/A" beside any questions not applicable to you.

Child's Name: _____ Birth date: _____
Parents' Names: _____
Would you prefer email correspondence? If so, email address _____
Who Referred you to The Eye Clinic? _____
Home Address:_____
Phone Number:_____ Best Phone # to call:_____
Person completing the Questionnaire_____
Date Questionnaire Completed_____

If you have received reports from other professionals such as psychologists, teachers, audiologists, speech therapists, occupational therapists, etc., it would be very helpful for you to send these reports to Dr. Matyas along with the questionnaire.

NOTES

- **The assessment is approximately 1 hour long**
- **Make sure your child is well rested on the day of the appointment**
- **If (s)he wears glass for reading, (s)he will need them for the testing**
- **Bring your child's health card**
- **Payment is by Visa, Mastercard or Debit**

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us.

We request a minimum of 48 hours notice if you are unable to keep this appointment.

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

Testing is one- on- one with the optometrist. For children under 5 years old, the parent is in attendance in the testing room; it is preferable not to bring other children with you because your attention is necessary during the evaluation.

PRESENT SITUATION AND SYMPTOMS

What are the concerns that prompted this vision skills assessment? _____

_____

How long have these concerns been observed?_____

What goals do you hope to accomplish from the vision skills assessment?_____

_____

_____

VISION

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? _____
Was surgery, therapy or other treatment recommend? Yes___No____
If yes, what? _____

_____

Put a check on the line if you have observed the following:

____An eye turns in or out
____Reddened or encrusted eyelids
____Frequent sties
____Eyes in constant motion
____Eyelids droop
____Stares at bright lights or repeatedly flicks objects in front of face
____Is abnormally bothered by bright light
____Seems visually unaware
____Has watery eyes
____Turns head to use one eye only
____Tilts head to one side
____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 crossing the midline of the body
____Is unable to stack blocks or other objects

DEVELOPMENTAL 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: _____

What things can your child do very well? _____

_____

What things, if any, are difficult for your child? _____

_____

CURRENT ABILITIES/BEHAVIOUR

Where appropriate, list the age at which your child could do the following: (some of these behaviours may not apply due to your child's chronological age).

	Age		Age
Responsive smile	_____	Stack blocks	_____
Crawl (stomach on floor)	_____	Walk alone	_____
Roll over	_____	Scribble spontaneously	_____
Creep (stomach of 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____ Below average____

How well developed is your child's spoken vocabulary? _____

How well does your child understand/respond to spoken language? _____

PRE-SCHOOL

******If your child attends preschool, please fill out the following:

Name of Pre-school: _____

Age at time of entrance to pre-school: _____

Does your child like pre-school? Yes ☐ No ☐

Does your child like teacher? Yes ☐ No ☐

Compared to other children his/her age, do his/her general performance and social skills seem to be

above ☐ equal to ☐ or below ☐

Please explain: _____

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: _____

_____

_____

MEDICAL HISTORY

Pediatrician's or Physician's Name: _____ Date of Last Evaluation: _____
For what reason? _____
Results and recommendations: _____

_____
Medications currently using, including vitamins and supplements: _____

_____

For what condition(s)? _____

_____

List illnesses, bad falls, high fevers, etc.:

Age	Severe	Mild	Complications

_____

_____

_____

Is your child generally healthy? Yes____No____
If no, explain: _____
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 and recommendations: _____

_____
Has a psychological evaluation been performed? Yes____No____
By whom? _____ Results and recommendations: _____

_____
Has an occupational therapy evaluation been performed? Yes____No____
By whom?_____ Results and recommendations: _____

_____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

_____

_____

_____

_____

_____

Is there any other information that would be helpful/important in our evaluation or treatment of your child? _____

_____

_____

March 2017