

# Parent Questionnaire

Name \_\_\_\_\_ Nickname \_\_\_\_\_ Birth Date \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_  
Parents/Guardians' Names \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Reason for Visit: \_\_\_\_\_  
\_\_\_\_\_

## Eye History

Is this your child's first exam Y N If no, when was his/her last eye exam \_\_\_\_\_  
Please describe any previous eye or vision problems, including any treatment received \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check any of the following that you have noticed or that your child complains about:

- |   |   |
|---|---|
| <input type="checkbox"/> blurred vision                   | <input type="checkbox"/> tilts head                       |
| <input type="checkbox"/> double vision                    | <input type="checkbox"/> headache                         |
| <input type="checkbox"/> closes or covers one eye to read | <input type="checkbox"/> eye strain                       |
| <input type="checkbox"/> eye turns in, out, up or down    | <input type="checkbox"/> red or watery eyes               |
| <input type="checkbox"/> eyes tired during near work      | <input type="checkbox"/> skips or re-reads lines          |
| <input type="checkbox"/> loses place during reading       | <input type="checkbox"/> words run together while reading |
| <input type="checkbox"/> poor depth perception            | <input type="checkbox"/> poor hand-eye coordination       |
| <input type="checkbox"/> squints or blinks excessively    |   |

## Educational History

Has your child repeated any grades \_\_\_\_\_ if so, which ones? \_\_\_\_\_

Does your child receive any special tutoring \_\_\_\_\_

Do you feel your child is performing up to their potential in school? Y N

## Developmental History

Were there any complications with pregnancy or child birth? Y N if so, please describe \_\_\_\_\_  
\_\_\_\_\_

Was your child born prematurely Y N If so, how soon? \_\_\_\_\_

Child's birth weight \_\_\_\_\_ Apgar Score \_\_\_\_\_

Did your child reach their developmental milestones on time? Y N

Was your child developmentally delayed? Y N

## Family Eye History

- Strabismus (eye turn)
- Amblyopia (lazy eye)
- Glasses
  
- Blindness

## Relation to child

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please continue form on back....

**Medical History**

Child's Pediatrician or Primary Care Provider \_\_\_\_\_

Location \_\_\_\_\_ Phone # \_\_\_\_\_

Please list any allergies: Medication \_\_\_\_\_ Food \_\_\_\_\_ Seasonal \_\_\_\_\_

Please list any medication and/or supplements that your child is current taking \_\_\_\_\_

Does your child have problems in the following areas? If so please describe in the space provided

**Yes**    **No**    **Endocrine**  
        Diabetes \_\_\_\_\_  
        Thyroid \_\_\_\_\_  
        Other \_\_\_\_\_

**Yes**    **No**    **Musculoskeletal**  
        JRA \_\_\_\_\_  
        Other \_\_\_\_\_

**Yes**    **No**    **Cardiovascular**  
        Heart Disease \_\_\_\_\_  
        High Blood Pressure \_\_\_\_\_  
        Arrhythmia \_\_\_\_\_  
        Anemia \_\_\_\_\_

**Yes**    **No**    **Psychiatric**  
        Depression \_\_\_\_\_  
        ADD \_\_\_\_\_  
        Other \_\_\_\_\_

**Yes**    **No**    **Neurological**  
        Seizures \_\_\_\_\_  
        Headache \_\_\_\_\_  
        Cerebral Palsy \_\_\_\_\_  
        Other \_\_\_\_\_

**Yes**    **No**    **Respiratory**  
        Asthma \_\_\_\_\_  
        Other \_\_\_\_\_

**Yes**    **No**    **Gastrointestinal/Genitourinary**  
        Stomach/Intestine \_\_\_\_\_  
        Genital \_\_\_\_\_  
        Kidney \_\_\_\_\_  
        Bladder \_\_\_\_\_  
        Other \_\_\_\_\_

**Yes**    **No**    **Skin**  
        Herpes Simplex \_\_\_\_\_  
        Eczema \_\_\_\_\_  
        Psoriasis \_\_\_\_\_  
        Other \_\_\_\_\_

**Yes**    **No**    **Other Major Illnesses**  
        Cancer \_\_\_\_\_  
        Other \_\_\_\_\_

Please describe any surgery your child has had, if any \_\_\_\_\_

---

Parent/Guardian Signature \_\_\_\_\_ Physician Signature \_\_\_\_\_  
Relationship \_\_\_\_\_ Date \_\_\_\_\_