



Norfolk
 220 W. Brambleton Ave. Ste. 111
 Norfolk, Virginia 23510
 (757) 622-0200

Virginia Beach
 1547 Laskin Road
 VB, Virginia 23451
 (757) 425-0200

PARENTS QUESTIONNAIRE

NAME:	NICK NAME	DATE OF BIRTH
SCHOOL	GRADE	TEACHER
PARENTS' NAMES		
OCCUPATIONS: MOTHER		FATHER
CHILD IS HERE TODAY BECAUSE:		
WHO FIRST NOTED POSSIBLE VISION DIFFICULTIES AND WHEN DID THEY START?		
WHO REFERRED YOU TO GILBERT EYECARE:		

VISUAL HISTORY:

IS THIS YOUR CHILD'S FIRST EYE EXAMINATION? Yes No If NOT, WHEN WAS THEIR LAST EXAMINATION?

PLEASE DESCRIBE ANY PREVIOUS EYE OR VISUAL PROBLEMS, AND TREATMENT YOUR CHILD HAS RECEIVED.
 (INCLUDING GLASSES, VISION THERAPY, PATCH, SURGERY, MEDICATION)

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE NOTICED OR THAT YOUR CHILD COMPLAINS ABOUT:

- | | |
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| <ul style="list-style-type: none"> BLURRED DISTANCE VISION DOUBLE VISION CLOSES OR COVERS ONE EYE DURING READING EYE TURNS IN, OUT, UP, DOWN FATIGUE DURING NEAR VISUAL TASKS SQUINTS OR BLINKS EXCESSIVELY HOLDS BOOK OR PAPER TOO CLOSE LOSS OF PLACE WHEN READING USES FINGER OR UNDERLINER TO READ POOR HAND EYE COORDINATION DIFFICULTY WITH SIMILARITIES AND DIFFERENCES IN LETTERS, PICTURES, OR WORDS | <ul style="list-style-type: none"> BLURRED VISION DURING READING WORDS MOVING OR RUNNING TOGETHER TILTS HEAD FREQUENT HEADACHES EYE STRAIN RED OR TEARY EYES AVOIDS CLOSE WORK SKIPS OR REREADS LINES FREQUENT REVERSAL POOR DEPTH PERCEPTION |
|--|---|

EDUCATIONAL HISTORY:

HAS YOUR CHILD REPEATED ANY GRADES? Yes No If YES, WHICH ONE?

IS YOUR CHILD RECEIVING ANY TUTORING, EXTRA HELP OR SPECIAL CLASSES IN SCHOOL? Yes No If YES, PLEASE DESCRIBE:

HAVE THERE BEEN ANY EVALUATIONS DONE AT SCHOOL OR BY SCHOOL RECOMMENDATION? (PSYCHOLOGICAL, LEARNING, SPEECH/LANGUAGE, OCCUPATIONAL THERAPY, NEUROLOGICAL, MEDICAL) Yes No If YES, PLEASE LIST TESTS AND BRIEFLY DESCRIBE THE RESULTS.

PLEASE CHECK IF YOUR CHILD HAS DIFFICULTIES IN ANY OF THE FOLLOWING AREAS:

- READING
 HANDWRITING
 MATH
 SPELLING
 COPYING FROM THE BOARD
 ATTENTION SPAN
 BEHAVIOR OR MOTIVATION

PARENTS QUESTIONNAIRE FORM

PLEASE CHECK THE FOLLOWING ASPECTS OF READING THAT ARE DIFFICULT OR ARE BEHAVIORS YOU HAVE NOTICED DURING READING:

COMPREHENSION	WORD RECOGNITION	PHONICS	SLOW READING
OMITS SMALL WORDS	FATIGUE	AVOIDANCE	COMPREHENSION DECLINES THE LONGER THEY READ

DO YOU FEEL YOUR CHILD IS PERFORMING UP TO THEIR POTENTIAL IN SCHOOL? Yes No

DOES YOUR CHILD ENJOY READING FOR PLEASURE? Yes No

DEVELOPMENTAL HISTORY

WERE THERE ANY COMPLICATIONS WITH PREGNANCY OR DURING BIRTH? Yes No If YES, PLEASE DESCRIBE

WAS YOUR CHILD BORN PREMATURELY? Yes No If YES, HOW SOON?

CHILD'S BIRTH WEIGHT? APGAR SCORE

WHEN DID YOUR CHILD BEGIN WALKING UNASSISTED? ON TIME DELAYED OR LATE

WHEN DID YOUR CHILD BEGIN TO SPEAK 2 TO 3 WORD PHRASES?

ANY SPEECH PROBLEMS NOW OR IN THE PAST? Yes No

ANY PROBLEMS WITH FINE MOTOR COORDINATION? Yes No

IS YOUR CHILD CLUMSY OR HAVE DIFFICULTY WITH ACTIVITIES SUCH AS DRAWING, COLORING, PUZZLES, BLOCK PLAY, ETC.?

(OR WITH OTHER CHILDREN, DID THEY PREVIOUSLY?) Yes No

MEDICAL HISTORY

HAS YOUR CHILD HAD ANY SEVERE CHILDHOOD ILLNESSES, HOSPITALIZATION, INJURIES, OR PHYSICAL IMPAIRMENTS? Yes No

If YES, PLEASE DESCRIBE

HAS YOUR CHILD HAD FREQUENT EAR INFECTIONS? Yes No If YES, WHAT TREATMENT HAVE THEY UNDERGONE?

ANY CURRENT HEALTH PROBLEMS? Yes No If YES, PLEASE DESCRIBE

IS YOUR CHILD TAKING ANY MEDICATIONS? Yes No If YES, PLEASE LIST MEDICATIONS

WHO IS YOUR CHILD'S PEDIATRICIAN OR PRIMARY CARE DOCTOR?

ANY SIGNIFICANT ALLERGIES? Yes No If YES, PLEASE DESCRIBE

WHEN WAS YOUR CHILD'S LAST PHYSICAL EXAMINATION?

FAMILY HISTORY

DOES ANYONE IN THE FAMILY HAVE ANY OF THE FOLLOWING?

	<u>RELATIONSHIP TO CHILD</u>
STRABISMUS (CROSS EYES)	
AMBLYOPIA (LAZY EYE)	
HIGH NEARSIGHTEDNESS, FARSIGHTEDNESS, OR ASTIGMATISM	
LEARNING OR READING PROBLEMS	
BLINDNESS	
EYE DISEASE (PLEASE LIST)	