Strasburg Family Eyecare, LLC

20 Lancaster Ave, Strasburg PA 17579 717-687-8141

Child Questionnaire

Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Business Phone:_____
Birth Date:_____ Age Now:_____ Occupation:_____
Do they currently attend school? Yes___ No___
Where?_____
Who referred you and why?_____
_____
Child's Doctor's :_____
Present Situation: In what ways is your child having visual difficulty?_____
_____
How long has this been going on?_____
List any current Medications:_____
Allergies:_____
Has anyone noticed an eye turn in or wander out?
_____Which?_____
Do they ever have any of the following, and if so when?
Headaches: Yes___No___When?_____
Blurred Vision Far: Yes___No___When?_____
Blurred Vision Near: Yes___No___When?_____
Double Vision: Yes___No___When?_____
Eyes Hurt or Tired: Yes___No___When?_____

Have you ever noticed the following?	Yes	No	When?
Holding reading close?	____	____	_____
Holding reading further away?	____	____	_____
Closing one eye?	____	____	_____
Covering one eye?	____	____	_____
Eyes frequently reddened?	____	____	_____
Frequent styes?	____	____	_____
Excessive eye rubbing?	____	____	_____
Get lost in book? Unaware peripherally?	____	____	_____
Tilting head when reading?	____	____	_____
Bothered by light?	____	____	_____
Inability to see distant objects?	____	____	_____
Bumping into objects?	____	____	_____
Poor general coordination?	____	____	_____
Have you had any eye surgeries?	____	____	_____
Have you ever had vision therapy?	____	____	_____
Have you ever injured you eye(s)?	____	____	_____

Health Information:

List any major illness:	Age	Mild	Severe
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Previous Visual Examination:

Reason	Dr's Name	Date	Results
_____	_____	_____	_____

Does your child like school? ____
Was a grade repeated?_____ Which one?_____
Was the work average: _____
Better than average: _____ Below than average:_____
What were the grades in:
Reading_____
Math _____
Spelling_____
Reading Support Teacher:_____
How does your child like to spend their free time:
_____
_____
_____

How many hours a day do they :
Use a computer?_____ Read?_____
Watch TV?_____ Play Video Games _____
Are they involved in sports? Y/N Which one_____
What kind of exercise do they do?_____

Visual History

Does your child wear contact lenses? Y / N
Have the worn contacts in the past? Y / N
Is a visual problem keeping them from doing anthing? Y / N
If yes, what _____
_____
_____

Family Members Visual Conditions:

Name	Age	Visual Situation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____