STEPHEN DALY
OPTOMETRIST

PARENT QUESTIONNAIRE FOR VISION EXAMINATION

In order to allow more time to devote to the assessment of your child and to better evaluate possible treatment alternatives, it would be appreciated if you could please complete the following information.

Child's Name ______________________________
Date of Birth ________________ Age now ____________
Address ____
____________________________ Postcode ____________
Phone: H ___________________ M ___________________
Email: ____
Father's Name _____________________________
Occupation _________________________W____________
Mother's Name ______________________________________
Occupation _________________________W____________

School Name ___________________________________
School Grade _____________________________________
Teacher's Name ___________________________________
Referred/recommended by __________________________
Teacher/ School Counsellor/ Learning Links/ Doctor/ Optometrist/ Friend/ or ____________________________
____
Brothers and sisters (names & ages) _________________
____
____

- What is the reason for this examination? ____
How long has the difficulty been noticed? ____

- Has your child reported, or have you or anyone else noticed, any of the following? (Please circle the number)

1. print blurs while reading
2. headaches
3. holds head close to books
4. blurriness after reading
5. difficulty copying from board to book
6. distance vision blur
7. excessive blinking/eye rubbing
8. avoids close work
9. short attention span while reading/writing

10. closing or covering one eye
11. one eye turns in or out
12. words or letters jump or run into each other
13. tilts head to one side while reading

14. poor general co-ordination or clumsy
15. difficulty catching tennis balls
16. trouble cutting with scissors
17. avoids colouring and tracing

18. difficulty printing and writing neatly
19. writes up and down hill
20. needs finger or marker to keep place reading
21. reads too slowly
22. loses place when reading
23. moves head across page while reading
24. skips or repeats words or lines when reading

25. confuses right and left
26. reverses words, letters or numbers
27. doesn't remember what was read
28. frequently misreads words
29. mistakes words with similar beginnings/endings
30. difficulty with spelling
31. difficulty learning sight words
32. trouble recognising words from one page or day to another
33. poor comprehension when read to
34. poor comprehension when they read

- School History

Age at entrance to kindergarten? _________Yr _____mth Has a grade been repeated? Yes / No which?
Does your child like school? Yes / No the teacher? Yes / No
Have there been any problems at school or factors interfering with your child's learning? Yes / No If yes, please describe
____
____
____
Is school work: below average / average / above average? ______________________________
Please describe your child's strengths and things that he/she is good at ____________________________

Please Turn Over...

Is your child performing at their highest level of potential? ____
____

- Developmental History

Were there any difficulties during pregnancy or birth? (eg premature, toxaemia, prolonged labour, traumatic birth, low birth weight, etc) Yes / No If so please describe ______________________________________
____

At what age did your child do the following:

Sit unsupported:__________ crawl on all fours : _____________ walk without assistance:__________

first words : __________ speak in sentences: __________ and was speech clear to others yes / no

What is the preferred hand ? right / left Has this ever changed ? yes / no

Did you have any concerns about your child's development? yes / no If so please describe ______________
____
____

Detail important aspects of past medical history (accidents, head/eye injuries, serious infections, high fevers, convulsions, surgeries, etc) giving age and severity ____
____
____

Is your child's present health: good / fair / poor ? List medications currently taken ___________________
____

- Visual History

Has your child had a complete vision examination ? Yes / No Date: _______ By whom ? _______________

Was treatment recommended and what? eg spectacles, patching, vision therapy ___________________________
____

List family history of vision problems to do with sight or eye health:
____
____
____

- Other Evaluations

Which other professionals has your child seen? eg Learning Links./ school counsellor / paediatrician / psychologist / speech therapist / occupational therapist / or ____

Briefly describe the problems found and the recommendations or treatments.
____
____
____
____

Is your child currently participating in any extra tutoring or therapy programmes? Yes / No Describe:
____
____

Signature: ____ Date: ______________________

As you complete this questionnaire you will recognise the thoroughness with which your child's problem will be considered and of how big a role vision plays in the life of your child. Your child's future deserves the fullest consideration that you as parents, and we in the practice, can provide.

Thank you,

Stephen Daly Jodie Errington