



CHILDREN'S QUESTIONNAIRE

**Please fill out this questionnaire carefully. It would be helpful to receive it prior to your appointment, by mail, sent to our office, or email to info@EagleEyeVisionCare.org
THANK YOU.**

GENERAL INFORMATION

Were you referred to our office? Yes No

If yes whom may we thank for this referral? _____ Phone: _____

Address: _____

Child's Full Name: _____

Birth Date: _____ Age: _____ years _____ months

Name and address of school: _____

Grade: _____ Teacher: _____ Reading Grade Level (if known): _____

Is your child especially afraid of doctors? Yes No

RESPONSIBLE PERSON INFORMATION

Father/Caretaker Name: _____

Mother/Caretaker Name: _____

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Email Address: _____

Eagle Eye Vision Care LLC does not contract directly with any insurance companies. We do ask that services are paid for in full at time of service. However, we will be happy to give your insurance company the appropriate documentation that they may reimburse you at out of network rates.

YOUR CHILD'S MEDICAL HISTORY:

Pediatrician's Name: _____

Is your child especially afraid of Doctors? Yes No

Last Visit Date: _____ For what reason? _____

Is your child generally healthy? Yes No

Medications (including vitamins and supplements):

Allergies to Medications: _____

Is there any history of the following? (please check if there is a history)

	<u>Patient</u>	<u>Family</u>	<u>Who</u>		<u>Patient</u>	<u>Family</u>	<u>Who</u>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>	_____	Chromosomal Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	_____

Any history in your family of an eye turn resulting from a disease or other condition? Yes No

Other health problems? Yes No

If yes, please explain: _____

Was there any related trauma, disease, or condition that preceded or accompanied the onset of the eye turn?

Yes No

If yes, please explain: _____

Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes No

If yes, please list: _____

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

<u>Age</u>	<u>Severe</u>	<u>Mild</u>	<u>Complications</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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: _____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes No

Did the mother experience any problems during pregnancy? Yes No

Normal birth? Yes No

Were forceps used? Yes No

Any complications before, during or immediately following delivery? Yes No

Did your child crawl (stomach on floor)? Yes No At what age? _____

Did your child creep (stomach off floor)? Yes No At what age? _____

At what age did your child sit up (without support)? _____

At what age did your child walk (without support)? _____

First words: _____ At what age? _____

At what age did your child speak in a simple sentence (string two words together)? _____

Was your child alert as an infant? Yes No

Were there ever any concerns regarding growth or development? Yes No

If so, explain: _____

Has your child undergone any of the following testing/treatment/therapy?

Educational	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Neurological	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Psychological	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Occupational	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Speech/Auditory	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Physical	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If yes, please list all previous evaluations done on your child:

Doctor or Institution Date(s) Type of Evaluation Results/Treatment/Intervention

NUTRITIONAL INFORMATION

Current Diet: Excellent Good Fair Poor

Are there any food allergies/sensitivities? Yes No

If so, explain: _____

Is your child active? Yes No Moderately Extremely

VISUAL HISTORY

Main reason for having an examination today: _____

Date of Last Evaluation: _____ Doctor's Name: _____

Reason for examination: _____

Results/recommendations: _____

Were glasses, contact lenses or other optical devices recommended? Yes No

If yes, are they used? Yes No If yes, when? _____

If no, why not? _____

Do you have any other concerns/observations concerning your child's vision? _____

Does your child report any of the following:

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes "hurt" or "tired"	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motion sickness/car sickness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness of the eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____

List any other complaints your child makes concerning his/her vision: _____

Do you feel your child's vision hinders his/her daily activities in any way? Yes No

If yes, how? _____

Have you or anyone else ever noticed the following:

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Eyes frequently reddened	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent eye rubbing	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent sties	<input type="checkbox"/>	<input type="checkbox"/>	
Frowning	<input type="checkbox"/>	<input type="checkbox"/>	
Bothered by light	<input type="checkbox"/>	<input type="checkbox"/>	
Closes or covers an eye	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty seeing distant objects	<input type="checkbox"/>	<input type="checkbox"/>	
Head close to paper when writing	<input type="checkbox"/>	<input type="checkbox"/>	
Avoids/dislikes reading or other near tasks	<input type="checkbox"/>	<input type="checkbox"/>	
Tilts head when reading or writing	<input type="checkbox"/>	<input type="checkbox"/>	
Moves head when reading	<input type="checkbox"/>	<input type="checkbox"/>	
Confuses letters and words	<input type="checkbox"/>	<input type="checkbox"/>	
Reverses letters or words	<input type="checkbox"/>	<input type="checkbox"/>	
Confuses right or left	<input type="checkbox"/>	<input type="checkbox"/>	
Skips, omits words	<input type="checkbox"/>	<input type="checkbox"/>	
Loses place when reading	<input type="checkbox"/>	<input type="checkbox"/>	
Uses finger as marker	<input type="checkbox"/>	<input type="checkbox"/>	
Poor reading comprehension	<input type="checkbox"/>	<input type="checkbox"/>	
Comprehension decreases over time	<input type="checkbox"/>	<input type="checkbox"/>	
Writes or prints poorly	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty copying form the chalkboard	<input type="checkbox"/>	<input type="checkbox"/>	
Tires easily	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with short term memory	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with long term memory	<input type="checkbox"/>	<input type="checkbox"/>	
Short attention span/loses interest	<input type="checkbox"/>	<input type="checkbox"/>	
Poor/awkward large motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	
Poor/awkward fine motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	
Dislikes/avoids sports	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty hitting/catching a ball	<input type="checkbox"/>	<input type="checkbox"/>	

RELEASE OF INFORMATION

We fully comply with the Health Insurance Portability and Accountability Act (HIPPA) and a full copy of the rules and regulations is available at your request. It is often beneficial to us to discuss examination results and to exchange information with your child's school, pediatrician, and/or other professionals involved in his/her care. Please sign below to authorize this exchange of information.

I agree to permit information from, or copies of, my child's examination records to be forwarded to other health care providers or insurance carriers upon their written request or upon the recommendation of the EAGLE EYE VISION CARE LLC when it is necessary for the treatment of my child's visual condition. I authorize Dr. Eagles and the Eagle Eye Vision Care to exchange information with my child's school and other professionals involved in my child's care by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

Parent's or Guardian's Signature

Date

I hereby give my permission to Eagle Eye Vision Care to treat: _____
(Child's Name)

Parent's or Guardian's Signature

Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation of your child and to better meet your child's specific visual needs.

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

You may leave a message for us 24 hours a day / 7 days a week. We request a minimum of 24 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.

If necessary, you are welcome to bring siblings to the evaluation. Keep in mind, however, that other children may be a distraction for you and the patient, this may reduce the efficiency of the evaluation.

THANK YOU.

Sincerely,

Keirsten D. Eagles, O.D., M.Ed.