PHILIP J. SCHAVILLE, O.D., P.C.
Doctor of Optometry

School Age
PARENTS QUESTIONNAIRE

Name_____Nickname_____ Birth Date _____
School _____ Grade_____Teacher_____
Parents' names: _____
Occupations: Mother: _____ Father: _____

A. Child is here today because:_____

_____

_____

_____

_____

1) Who first noted possible visual difficulties and when did they start?_____
2) Who referred you to our office? _____

B. VISUAL HISTORY

1) Is this your child's first visual examination? Yes ____ No____ If not, when was their last examination? _____
2) Please describe any previous eye or visual problems, and treatment your child has received. (including glasses, vision therapy, patch, surgery, medication)._____

_____

_____

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

___ 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 eye-hand coordination
___ difficulty with similarities and differences in letters, pictures, or words
___ 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 reversals
___ poor depth perception

C. EDUCATIONAL HISTORY

1) Has your child repeated any grades? Yes ____ No ____ If yes, which one? ____
2) Is your child receiving any tutoring, extra help or special classes in school? Yes ____ No ____ If yes, please describe.

_____

_____

3) 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._____

_____

4) Please check if your child has difficulties in any of the following areas:

_ reading
_ spelling
_ behavior or motivation
___ handwriting
___ copying from the board
___ math
___ attention span

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5) Please check if any of the following aspects of reading are difficult or are behaviors you have noted during reading:

___ comprehension
___ slow reading
___ avoidance
___ word recognition
___ omits small words
___ comprehension declines the longer they read
___ phonics
___ fatigue

6) Do you feel your child is performing up to their potential in school? Yes ____ No ____
7) Does your child enjoy reading for pleasure? Yes ____ No ____

D. DEVELOPMENTAL HISTORY

1)Were there any complications with pregnancy or during birth? Yes ____ No ____ If yes, please describe _____
_____
2) Was your child born prematurely? Yes ____ No ____ If yes, how soon? _____
3) Child's birth weight_____ Apgar Score_____
4) When did your child begin walking unassisted? early ____ on time ____ delayed or late ____
5) When did your child begin to say 2 to 3 word phrases? _____
6) Any speech problems now or in the past? Yes ____ No ____
7) Any problems with fine motor coordination? Yes ____ No ____
8) Is your child clumsy or have difficulty with activities requiring good balance? Yes ____ No ____
9) Does your child enjoy and participate in activities such as drawing, coloring, puzzles, block play, etc.? (or with older children, did they previously?) Yes ____ No ____

E. MEDICAL HISTORY

1) Has your child had any severe childhood illnesses, hospitalizations, injuries, or physical impairments? Yes ____ No ____
If yes, please describe:_____
2) Has your child had frequent ear infections? Yes ____ No ____ If yes, what treatments have they undergone?_____
_____
3) Any current health problems? Yes ____ No ____ If yes, please describe: _____
4) Is your child taking any medications? Yes ____ No ____ If yes, list drugs and doctor that has prescribed them:_____
_____
5) Who is your child's pediatrician or primary doctor? _____
6) Any significant allergies? Yes ____ No ____ If yes, please describe:_____
7) When was your child's last physical examination? _____

F. FAMILY HISTORY

1) Does anyone in the family have any of the following?

	Relationship to child
__ strabismus (crossed eyes)	_____
__ amblyopia (lazy eye)	_____
__ high nearsightedness, farsightedness, or astigmatism	_____
__ learning or reading problems	_____
__ blindness	_____
__ eye disease (please list) _____	_____

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