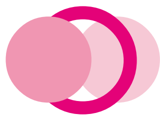

vedelago optometrists

Unit 5, Plains Junction
24 – 48 Browns Plains Rd
Browns Plains
QLD 4118
P 07 3800 5013
F 07 3800 0359
E info@vedelago.com.au

Childrens Vision Questionnaire

Thank you for taking the time to complete this form. The information that you give will be helpful in gaining an understanding of your child's current level of visual skills. The information will be of great assistance to the optometrist, as it will allow us more time to devote to the assessment of your child. All information will remain strictly confidential and used for the purpose of the visual assessment only.

Child's name ______________________________

Date of birth ______/______/ ____________________ Age _______ years _______ months

Referred or recommended by ______________________________

Main reason for visual examination ______________________________

Parent's/Guardian's email address ______________________________

Phone (Home) ____________________ (Work) ____________________ (Mobile) ____________________

Grade ____________________ School ____________________

Father's name ____________________ Occupation ____________________

Mother's name ____________________ Occupation ____________________

Sibling's name ____________________ Age ____________________

Sibling's name ____________________ Age ____________________

Would you like us to keep you informed about new products/promotions? Via: ☐ SMS ☐ email ☐ either ☐ no thanks

As part of our continuous improvement program, we would like to send you a one question email survey. It will only take one minute and it's anonymous. Would you be happy for us to send you this email? ☐ Yes ☐ No

Medical History and General Health

Has your child had any serious illness or injury in the past or at present?

☐ No ☐ Yes – please detail: ______________________________

Has your child suffered any previous head or eye injury?

☐ No ☐ Yes – please detail: ______________________________

Does your child have a history of:

☐ asthma ☐ middle ear infections ☐ tonsillitis ☐ bronchitis ☐ chronic headaches ☐ high fever

☐ others ____________________ At what age? ____________________

Detail any current medications being taken: ______________________________

Detail any food intolerance or allergies to medications or environment: ______________________________

Visual History

Has your child had a previous visual assessment? ☐ No ☐ Yes – approximate date ____________________

If yes, assessed by: ☐ optometrist ☐ ophthalmologist ☐ school nurse screening

What was recommended? ☐ spectacles ☐ vision therapy ☐ surgery ☐ other treatment

Educational History

Does your child like school? ☐ No ☐ Yes

Has your child repeated a grade? ☐ No ☐ Yes – which grade? ____________________

Has there been any remedial teaching or tutoring? ☐ No ☐ Yes – please detail ____________________

Please give approximates of your child's performance in:

Reading: ☐ Above average ☐ average ☐ below average Spelling: ☐ Above average ☐ average ☐ below average

Maths: ☐ Above average ☐ average ☐ below average Writing: ☐ Above average ☐ average ☐ below average

Has your child been assessed by the following? (if possible, please bring along any relevant report to the appointment.)

☐ Educational psychologist ☐ Paediatrician ☐ Occupational Therapist ☐ Speech Therapist ☐ Audiologist

☐ School Guidance Officer ☐ Others ______________________________

Developmental History

Did mother have any problems during pregnancy? (eg. blood pressure, toxaemia, bleeding)

☐ No ☐ Yes – please detail ________________________________

Was your child premature? ☐ No ☐ Yes – premature by _______weeks

Any problems during delivery? ☐ No ☐ Yes – please detail ________________________

At what age were first words spoken?_______ months. First sentence? _______ months

Any problems with development of spoken vocabulary and / or sentence structure?

☐ No ☐ Yes – please detail ________________________________

Did your child have problems crawling on all fours? (eg. dragged legs)

☐ No ☐ Yes – please detail ________________________________

At what age did your child first crawl? _______ months. First walk? _______ months

Has your child ever had difficulties with fine hand co-ordination? (eg. cutting, tying shoe laces, colouring in etc.)

☐ No ☐ Yes – please detail ________________________________

Any problems with pencil grip for handwriting? ☐ No ☐ Yes

Which is your child's preferred hand? ☐ Right ☐ Left ☐ Either

Is your child: ☐ hyperactive ☐ distractible ☐ impulsive ☐ short attention ☐ other ______________

Signs and symptoms of vision problems

Observed:	never	sometimes	often	usually
APPEARANCE OF EYES				
Crossed eyes – turning in or out	☐	☐	☐	☐
Watering or bloodshot eyes	☐	☐	☐	☐
Red rimmed, crusted or swollen lids	☐	☐	☐	☐
Recurrent styes or infections	☐	☐	☐	☐
DOES YOUR CHILD COMPLAIN OF				
Headaches (particularly at the end of the day)	☐	☐	☐	☐
Difficulty seeing clearly at distance	☐	☐	☐	☐
Blurry, 'funny', 'fuzzy' vision while reading or writing	☐	☐	☐	☐
Print goes double, run together or swirls when reading	☐	☐	☐	☐
Eyes burn, itch or become sore during or after close work	☐	☐	☐	☐
Glare sensitivity	☐	☐	☐	☐
WRITING AND OTHER DESK TASKS				
Turns head to one side excessively when writing	☐	☐	☐	☐
Difficulty copying from book or chalkboard	☐	☐	☐	☐
Holds head too close to desk when writing	☐	☐	☐	☐
Writes neatly but too slowly	☐	☐	☐	☐
Letter / numeral reversals (eg. b for d)	☐	☐	☐	☐
READING				
Holds book too close when reading	☐	☐	☐	☐
Comprehension drops with time	☐	☐	☐	☐
Skips small (known) words	☐	☐	☐	☐
Inserts/ substitutes small words	☐	☐	☐	☐
Loses place	☐	☐	☐	☐
Skips lines	☐	☐	☐	☐
Uses finger or marker as pointer	☐	☐	☐	☐
Reading becomes hesitant after a short period, even on well known material	☐	☐	☐	☐
Rubs eyes during or after a short period of reading	☐	☐	☐	☐
Becomes irritable, tense, nervous or restless after reading for a short while	☐	☐	☐	☐
Becomes excessively fatigued when reading	☐	☐	☐	☐
Turns/ tilts head to one side when reading	☐	☐	☐	☐
Closes or covers one eye when reading	☐	☐	☐	☐
BODY POSTURE / SPATIAL AWARENESS				
Unusually awkward when walking / running	☐	☐	☐	☐
Frequent tripping or stumbling	☐	☐	☐	☐
Confuses right and left directions	☐	☐	☐	☐

SUBMIT