Questionnaire

Private and Confidential

VISION WEST
Optometrists & Contact Lens Consultants

Ground Floor Northcourt Building
Karrinyup Shopping Centre
Burroughs Road Karrinyup WA 6018
Email: visionwest@iinet.net.au
Phone: (08) 9445 1499
Fax: (08) 9244 4436
ABN 24 050 159 549

Please fill in the following information about your child prior to their appointment. The history and background information helps us determine what examination routines will best apply to your child.

Patient Name: _____ Date of Exam: _____

Address: _____ Post Code: _____

Date of Birth: _____ Age: _____ Number of Children in Family: _____
Order of child in family (eg: eldest of two, etc): _____

Name of School: _____ Grade: _____ Teacher's Name: _____

Father's Name: _____ Occupation: _____ Phone Hm: _____
Email: _____Mobile:_____

Mother's Name: _____ Occupation: _____ Phone Hm: _____
Email: _____Mobile:_____

Have you been to another Optometrist within the last 36 months? _____

If so, can you remember whom you saw:_____

Who recommended you to our practice? _____

Family Doctor's name: _____ Suburb: _____

What other professionals have you consulted?_____

Do you have a Private Health Fund? Yes ☐ No ☐ Name _____

Do you have a Medicare card? Number: _____Ref:_____Expiry:_____

Is your child on any medication? Yes ☐ No ☐ Please list _____

A Present Situation

1 What is the main reason for this visit? _____

2 In what way does your child seem to have visual difficulty? _____

3 Does your child complain about their vision? Yes ☐ No ☐

4 Does your child report any of the following, and if so, when?

	Yes	No	When?
Headaches			
Blurred Distance vision			
Vision blurred when reading			
Double vision			
Sore or Tired Eyes			

B Visual History

How long ago was the difficulty noticed?_____ List previous visual examinations:

Name	Doctor / Optometrists Name	Results

C School

1 Child's age at time of entrance? _____

2 Does your child like: School? Yes ☐ No ☐ Teacher? Yes ☐ No ☐

3 Has a grade been repeated? Yes ☐ No ☐ If any, which grade? _____

4 Has there been any school difficulties? Yes ☐ No ☐ Explain if "yes" _____

_____

5 Is school work: average/ above average/ below average?

6 Are there any subjects which seem particularly easy for the child? _____
or particularly difficult for the child? _____

7 Does your child reverse letters/numbers? Yes ☐ No ☐

8 Does your child have difficulty with: Spelling? Yes ☐ No ☐ Reading? Yes ☐ No ☐
Comprehension? Yes ☐ No ☐ Mathematics? Yes ☐ No ☐
Writing? Yes ☐ No ☐

D Gross Motor Development

Crawled at age: _____ Walked alone at age: _____ Hand preference clearly indicated by age: _____

Writing R/L hand:_____ Sport R/L hand:_____

Watches Television _____ hrs/day Computer _____ hrs/day (include Game boy/ Playstation etc)

Gross Motor Development	Yes	No	Gross Motor Development	Yes	No
Fell down a lot			Had playpen		
Walked on toes			Had walker		
Hyperactive unnecessarily			Arms or legs required braces or cast		
Can child tie shoe laces?			Reluctant to do physical activity		

E Illnesses:

Illnesses	Age	Circumstance	Illnesses	Age	Circumstance
ADD/ADHD			Allergies		
Dehydration			Sinus Trouble		
Blood Transfusion			Anaemic		
Convulsions			Thyroid Problems		
Meningitis			High Fever		
Measles			Catches Cold Easily		
Surgery			Tonsils Removed		
Whooping cough			Grommets Fitted		
Hyperactive			Other		
Hypoglycaemic					

F Have you or anyone else ever noted the following?

	Yes	No	When?
Eyes frequently bloodshot?			
Frequent styes?			
Excessive rubbing?			
Excessive blinking?			
Getting lost in book?			
Tilting head when reading?			
Bumping into objects?			
Poor general co-ordination?			
Large pupils in normal light?			
Bothered by light?			
Holding reading close?			
Closing one eye?(in the sun or reading)			
Covering one eye?			

G Habits

Habits	Age	Duration	Habits	Age	Duration
Head Banger			Mood Swings		
Temper Tantrums			High Fluid Intake		
Stopped bed wetting at age?			Sucked Thumb		
Teeth Grinding			Breath Holding Spells		
Drooling			Requires constant discipline		
Upset Easily			Other		
Impulsive					

H Family History

Family History	Yes	No	Family History	Yes	No
Seizures			Learning difficulties		
Epilepsy			Twin		
Intellectually disabled			Colour Vision Defect		
Cerebral Palsy			Crossed-eye or wall-eyed		
Reading Problems			Amblyopia (Lazy Eye)		
Allergies			Strong Glasses		
Glaucoma			Diabetes		

Please list members of the family who have had visual attention and why:

Name	Age	Visual Situation

Thank you for taking the time to fill in this questionnaire, this will help us to give your child the best possible vision care.

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