VISION CARE & THERAPY CENTER
12020 Etris Rd Suite B-100 Roswell, GA 30075 678.256.3990

JANNA IYER, O.D.
Clinical Director

CHILDRENS VISION QUESTIONNAIRE

Please fill out this questionnaire carefully. THANK YOU.

Child's Full Name: _____ Male ▫ Female ▫

Birth Date: _____ Age: _____ years _____ months

Home Address: _____

Cell Phone: _____ Parent/Guardian Daytime Phone: _____

Were you referred to our office? Yes ▫ No ▫

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

Address _____

Do you have Major Medical Insurance? Yes ▫ No ▫

If yes, who is the carrier? _____ Policy #: _____

Does the insurance cover eye examinations or glasses? Yes ▫ No ▫

Name of Insured: _____

Social Security Number: _____ Driver's License No.: _____

Name and address of school: _____

School work is: Above average ▫ Average ▫ Below average ▫

What school subjects are easy for child? _____

What school subjects are difficult for child? _____

Are there any concerns regarding behavior/school performance? Yes ▫ No ▫

Please Explain: _____

_____

Please list the names and birth dates of your family:

NAME

Father/Caretaker _____ Birth Date _____

Mother/Caretaker _____ Birth Date _____

Siblings _____ Birth Date _____

Siblings _____ Birth Date _____

Siblings _____ Birth Date _____

Siblings _____ Birth Date _____

MEDICAL HISTORY

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

	Patient	Family	Who		Patient	Family	Who
Diabetes	▫	▫	_____	Cancer	▫	▫	_____
Blindness	▫	▫	_____	Multiple Sclerosis	▫	▫	_____
Eye Turn	▫	▫	_____	Brain Tumor	▫	▫	_____
Glaucoma	▫	▫	_____	ADD / ADHD	▫	▫	_____

	Patient	Family	Who		Patient	Family	Who
High Blood Pressure	▫	▫	_____	Cataracts	▫	▫	_____
Eye Infections	▫	▫	_____	Lazy Eye	▫	▫	_____
Thyroid Condition	▫	▫	_____	Eye Disease	▫	▫	_____
Eye Surgery	▫	▫	_____	Ear infections	▫	▫	_____

Please explain: _____

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

For what problem / condition? _____

Results and recommendations: _____

Medications currently using including vitamins and supplements: _____

For what condition(s)? _____

Is your child allergic to any foods or medications? Yes ▫ No ▫

If yes, please list: _____

Child's current diet: Good ▫ Fair ▫ Poor ▫

Child's current state of health (explain): _____

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 observe or does your child report any of the following:

	Yes	No	If yes, when?
Headaches	▫	▫	_____
Blurred vision	▫	▫	_____
Double vision	▫	▫	_____
Eyes "hurt" or "tired"	▫	▫	_____
Nausea when doing visual tasks	▫	▫	_____
Motion sickness / car sickness	▫	▫	_____
Bothered by light / sun light	▫	▫	_____
Frequent sties	▫	▫	_____
Eyes itch	▫	▫	_____
Eyes burn	▫	▫	_____
Eyes tear	▫	▫	_____
Eyes frequently reddened	▫	▫	_____

	Yes	No	If yes, when?
Closing or covering one eye	□	□	_____
Loses place while reading	□	□	_____
Poor reading comprehension	□	□	_____
When reading, letters/words appear to move or float around	□	□	_____
Loses attention easily	□	□	_____
Difficulties with memory	□	□	_____
Reversing numbers, letters, or words	□	□	_____

Has your child suffered any blows or injuries to head, eyes or neck? Yes □ No □

If yes, describe: _____

Are there any other complaints your child makes concerning his vision? _____

_____

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

_____

RELEASE OF INFORMATION AND INSURANCE FILING

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 VISION CARE & THERAPY CENTER when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I authorize VISION CARE & THERAPY CENTER 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.

If records or reports are requested by my child's school district, I authorize their release.

This authorization shall be considered valid for the duration of treatment.

_____

Signature of parent or guardian Date

I hereby give my permission to the VISION CARE & THERAPY CENTER 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 at any time you have any questions or concerns regarding your child's vision or treatment, 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 evaluation, so that we will have the maximum opportunity to evaluate your child's visual status.

Please do not bring any other children with you because your undivided attention is necessary during the evaluation.

Thank you.

Sincerely,

Janna Iyer, O.D.
Clinical Director