BRIER CREEK VISION CARE
& THE CENTER FOR VISUAL LEARNING & REHABILITATIVE THERAPY
Susan L. Durham, O.D., F.C.O.V.D.
Pooja J. Patel, O.D., F.A.A.O.
10207 Cerny Street, Suite 100 Raleigh, NC 27617 (919) 361-2299 phone (919) 361-0055 fax www.briercreekvision.com

CHILD/ADOLESCENT VISION & MEDICAL HISTORY QUESTIONNAIRE

Please complete this questionnaire carefully and return it to our office as soon as possible.

GENERAL INFORMATION

Patient's Full Name: ____________________ Male ☐ Female ☐

Birth Date: ____________________ Age: _____years _____months

School: ____________________ Grade level: ____________________

Please list the names and birth dates of patient's family members:

Father/Caretaker ____________________ Birth Date ____________________
Mother/Caretaker ____________________ Birth Date ____________________
Sibling ____________________ Birth Date ____________________
Sibling ____________________ Birth Date ____________________
Sibling ____________________ Birth Date ____________________
Sibling ____________________ Birth Date ____________________

RESPONSIBLE PERSON INFORMATION

Home Address: ____________________ City: ____________________ Zip: ____________________
Father/Caretaker's Occupation: ____________________ Business Phone: ____________________
Father's E-mail Address: ____________________ Father's Cell Phone: ____________________
Mother/Caretaker's Occupation: ____________________ Business Phone: ____________________
Mother's E-mail Address: ____________________ Mother's Cell Phone: ____________________
Do you have Major Medical Insurance? Yes ☐ No ☐
If so, who is the carrier? ____________________ Policy #: ____________________
Name of Insured: ____________________ Date of birth: ____________________
Social Security Number: ____________________

Were you referred to our office? Yes ☐ No ☐

If yes, whom may we thank for this referral? ____________________

MEDICAL HISTORY

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

Current medications and reason for taking them (including vitamins and supplements): ____________________

____

____

Drug Allergies: ____________________

List illnesses, bad falls, high fevers, etc (include age at occurrence):

____

____

____

Is your child generally healthy? Yes ☐ No ☐ If no, explain: ____________________

____

Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes ☐ No ☐
If yes, please list: ____

____

Has a neurological and/or psychological evaluation been performed? Yes ☐ No ☐
By whom? ____________________ Results and recommendations: ____________

____

Has a psychoeducational evaluation been performed? Yes ☐ No ☐
By whom? ____________________ Results and recommendations: ____________

____

Has an occupational therapy evaluation been performed? Yes ☐ No ☐
By whom? Results and recommendations: ______________________________

____

Has a speech therapy evaluation been performed? Yes ☐ No ☐
By whom? Results and recommendations: ______________________________

____

MEDICAL HISTORY:

	Patient	Family	Relation/Details
High blood pressure	☐	☐	________
Heart disease	☐	☐	________
High cholesterol	☐	☐	________
Stroke	☐	☐	________
Diabetes/Endocrine	☐	☐	________
Blood/lymphatic	☐	☐	________
Arthritis	☐	☐	________
Cancer (type)	☐	☐	________
Lung Disease (asthma/emphysema)	☐	☐	________
Thyroid Disease	☐	☐	________
GI disease (ulcers/acid reflux)	☐	☐	________
Infectious disease (HIV/hepatitis)	☐	☐	________
Acquired/Traumatic Brain Injury	☐	☐	________
Ear, nose, throat (allergies)	☐	NA	________
Kidney, Bladder, Genital	☐	NA	________
Neurological	☐	NA	________
Depression	☐	NA	________
Anxiety	☐	NA	________

Surgeries: (list)

____

____

OCULAR HISTORY	Patient	Family	Relation/Details
Glaucoma	☐	☐	________
Cataracts	☐	☐	________
Macular degeneration	☐	☐	________
Retinal disorders	☐	☐	________

	Patient	Family	Relation/Details
Blindness	☐	☐	____________
Strabismus/eye turn	☐	☐	____________
Amblyopia/lazy eye	☐	☐	____________
Eye injuries	☐	☐	____________
Eye surgeries	☐	☐	____________

Others: (list) ____

DEVELOPMENTAL HISTORY

Full-term pregnancy: Yes ☐ No ☐

Normal birth: Yes ☐ No ☐ Birth weight: ____________

Did the mother experience any health problems during the pregnancy? Yes ☐ No ☐

If yes, explain: ____

Were there any complications before, during or immediately following delivery? Yes ☐ No ☐

If yes, explain: ____

Were forceps used? Yes ☐ No ☐

Was there ever any reason for concern over your child's general growth or development during the first year of life? Yes ☐ No ☐ If yes, why? ____________________

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

Did your child creep (on all fours)? Yes ☐ No ☐ At what age? ____________

At what age did your child walk? ________ Speech: At what age: ____________

Speech concerns at this time? Yes ☐ No ☐ ____________________

VISUAL HISTORY

Why do you feel your child needs a vision examination? ____________________

____

____

Has your child's vision been previously evaluated? Yes ☐ No ☐

If yes, Doctor's name: ____________________Date of last evaluation: ____________

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

If yes: single vision ☐ line bifocal ☐ no-line bifocal ☐ contact lenses ☐

Are they worn? Yes ☐ No ☐ If yes, when? ________If no, why not____________

If contact lenses are worn, what type are they? Soft ☐ Rigid ☐ Gas Permeable ☐

If soft, how often are they replaced? daily ☐ 2 weeks ☐ monthly ☐ 3 months ☐ yearly ☐

How long have contacts been worn? ____________________

If not worn full time, when are they worn? ____________________

How old are the current contact lenses? ________ What solutions are used? ____________

Are there any problems with the current optical prescription? Yes ☐ No ☐

If yes, explain: ____

Were any additional tests, treatments, or therapies recommended? Yes ☐ No ☐

If yes, what? ______________________________

Did the patient undergo these treatments? Yes ☐ No ☐ Explain: ______________________________

Results and recommendations______________________________

Are any of the following symptoms reported?	**Yes**	**No**	**If yes, when?**
Difficulty seeing distance objects	☐	☐	____________
Vision gets blurry when reading	☐	☐	____________
Frequent eye rubbing	☐	☐	____________
Excessive blinking	☐	☐	____________
Red/bloodshot eyes	☐	☐	____________
Eyes water	☐	☐	____________
Eyes itch	☐	☐	____________
Eyes burn	☐	☐	____________
Bothered by light	☐	☐	____________
Eyes feel strained after short periods of reading or close work	☐	☐	____________
Fatigues quickly when reading	☐	☐	____________
Dislikes or avoids reading/close work	☐	☐	____________
Reads slowly	☐	☐	____________
Letters/words run together/move when reading	☐	☐	____________
Loss of place or omits words when reading	☐	☐	____________
Rereads or skips lines unknowingly	☐	☐	____________
Needs finger/marker to keep place reading	☐	☐	____________
Holds head close to paper when read/write	☐	☐	____________
Eye turns in/out/up or down	☐	☐	____________
Complains of seeing double	☐	☐	____________
Closes or covers one eye when reading	☐	☐	____________
Tilts or turns head to one side excessively	☐	☐	____________
Gets headaches when reading	☐	☐	____________
Motion sickness	☐	☐	____________
Car sickness	☐	☐	____________
Short attention span	☐	☐	____________
Reverses letters, numbers or words	☐	☐	____________
Confuses right and left	☐	☐	____________
Sloppy handwriting	☐	☐	____________
Excessive erasures	☐	☐	____________
Awkward or immature pencil grip	☐	☐	____________
Fails to recognize same word in next sentence	☐	☐	____________
Difficulty copying from the board	☐	☐	____________
Poor ability to remember what is read	☐	☐	____________
Difficulty with memory	☐	☐	____________
Difficulty judging distances	☐	☐	____________
Difficulty hitting and/or catching a ball	☐	☐	____________

SCHOOL

Has a grade been repeated? Yes ☐ No ☐

If yes, which and why? ______________________________

Seems to be under tension or extreme pressure when doing school work? Yes ☐ No ☐

Have there been any special tutoring, therapy, and/or remedial assistance? Yes ☐ No ☐

If yes, describe: ____

____

Does the patient read voluntarily? Yes ☐ No ☐

What is the patient's attitude towards school/teachers/classmates? ______________________

Overall schoolwork is: above average ☐ average ☐ below average ☐

Is a lot of time/effort spent to maintain this level of performance? Yes ☐ No ☐

How much time on average is spent each day on homework assignments? ______________

To what extent does a parent assist the patient with homework? ______________________

Do you feel the patient is achieving up to potential? Yes ☐ No ☐

Does the teacher feel that patient is achieving up to potential? Yes ☐ No ☐

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

How much time is spent watching TV, or playing on computer/video games per day? __________

What other activities occupy patient's leisure time? ______________________________

____

GENERAL BEHAVIOR

Are there any behavior problems at school? Yes ☐ No ☐ If yes, what? .______________

Are there any behavior problems at home? Yes ☐ No ☐ If yes, what? .______________

What causes these problems? ______________________________________

FAMILY AND HOME

Please indicate which adult(s) patient lives with? Mother ☐ Father ☐ Stepmother ☐
Stepfather ☐ Foster Parents ☐ Adoptive Parents ☐ Grandmother ☐ Grandfather ☐
Aunt ☐ Uncle ☐ Other Caretaker (please specify): ______________________________

GIVE A BRIEF DESCRIPTION OF PATIENT AND PLEASE ADD ANY OTHER INFORMATION THAT WOULD BE HELPFUL OR IMPORTANT FOR OUR TREATMENT:

____

____

____

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____

____

____

For Office Use Only

O.D. Initial ___________________ Date: _______________

RELEASE OF INFORMATION AND INSURANCE FILING

IT IS OFTEN BENEFICIAL FOR US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH YOUR CHILD'S SCHOOL 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 my child's school, other health care providers or insurance carriers upon their written request or upon the recommendation of ***Brier Creek Vision Care*** when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. This authorization shall be considered valid throughout the duration of treatment by means of my signature as indicated below.

___________________________________ ___________________________________

Signature Date

____

Relationship to patient

I hereby give my permission to ***Brier Creek 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 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.

Missed appointment fee is $50 without 24 hour notice.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your child's visual status.

THANK YOU.

The Staff of Brier Creek Vision Care
&The Center for Visual Learning & Rehabilitative Therapy