BRIER CREEK VISION CARE & THE CENTER FOR VISUAL LEARNING & REHABILITATIVE THERAPY
Susan L. Durham, OD, FCOVD Pooja J. Patel, OD, FAAO Esther Nakagawara, OD, FAAO
9650 Brier Creek Parkway, Suite 107 Raleigh, NC 27617 (919) 361-2299 phone (919) 361-0055 fax www.briercreekvision.com

CHILD/ADOLESCENT VISION AND 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: _____

RESPONSIBLE PERSON INFORMATION

Father/Caretaker Name: _____

Father/Caretaker's Occupation: _____ Business Phone: _____

Father's E-mail Address: _____ Father's Cell Phone: _____

Mother/Caretaker Name: _____

Mother/Caretaker's Occupation: _____ Business Phone: _____

Mother's E-mail Address: _____ Mother's Cell Phone: _____

Were you referred to our office? Yes ☐ No ☐ If yes, by whom: _____

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)	☐	☐	_____
Thyroid Disease	☐	☐	_____
Lung Disease (asthma/emphysema)	☐	☐	_____
Ear, nose, throat (allergies)	☐	NA	_____
GI disease (ulcers/acid reflux)	☐	NA	_____
Kidney, Bladder, Genital	☐	NA	_____
Neurological	☐	NA	_____
Acquired/Traumatic Brain Injury	☐	NA	_____
Depression	☐	NA	_____
Anxiety	☐	NA	_____
Infectious disease (HIV/hepatitis)	☐	NA	_____

Surgeries (list): _____

OCULAR HISTORY

	Patient	**Family**	**Relation/Details**
Glaucoma	☐	☐	_____
Cataracts	☐	☐	_____
Macular degeneration	☐	☐	_____
Retinal disorders	☐	☐	_____
Blindness	☐	☐	_____
Strabismus/eye turn	☐	☐	_____

	Patient	Family	Relation/Details
Amblyopia/lazy eye	☐	☐	_____
Eye injuries	☐	NA	_____
Eye surgeries	☐	NA	_____

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? _____ At what age did your child speak? _____

Current speech concerns? Yes ☐ No ☐ _____

VISUAL HISTORY

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

_____

Has there been a previous vision evaluation? 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 ☐ Lined bifocal ☐ No-line bifocal ☐ Contact lenses ☐

Are they worn? Yes ☐ No ☐ If yes, when? If no, why not? _____

_____

If wearing contact lenses, what type are they? Soft ☐ Rigid Gas Permeable/Hard ☐

Soft contact lens brand and power: _____

How many days per week are contacts worn, on average? _____

How frequently are contact lenses replaced? _____

How many nights per week are contact lenses slept in? _____

What disinfection/storage solutions are used? _____

How many years have contact lenses been worn? _____

Contact lens comfort is: Good ☐ Fair ☐ Poor ☐

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

If yes, explain: _____

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

If yes, what? _____

Did you undergo these treatments? Yes ☐ No ☐ Explain: _____

Results and recommendations: _____

VISUAL SYMPTOMS

Please check the appropriate column for each symptom listed when wearing glasses or contact lenses (if used).

	Often	**Sometimes**	**Never**	**Details**
Difficulty seeing distance objects	☐	☐	☐	_____
Vision gets blurry when reading	☐	☐	☐	_____
Frequent eye rubbing and/too much blinking	☐	☐	☐	_____
Eyes water/itch/burn	☐	☐	☐	_____
Eyestrain/fatigue with short term reading	☐	☐	☐	_____
Headaches when reading	☐	☐	☐	_____
Dislikes or avoids reading/close work	☐	☐	☐	_____
Reads slowly	☐	☐	☐	_____
Letters/words run together/move when reading	☐	☐	☐	_____
Loss of place or skips words when reading	☐	☐	☐	_____
Rereads or skips lines unknowingly	☐	☐	☐	_____
Needs finger/marker to keep place reading	☐	☐	☐	_____
Holds head close to paper when reads/writes	☐	☐	☐	_____
Eye turns in/out/up/down	☐	☐	☐	_____
Complains of seeing double when reading	☐	☐	☐	_____
Closes or covers one eye when reading	☐	☐	☐	_____
Tilts or turns head to one side excessively	☐	☐	☐	_____
Motion sickness	☐	☐	☐	_____
Car sickness	☐	☐	☐	_____
Short attention span	☐	☐	☐	_____
Reverses letters, numbers or words	☐	☐	☐	_____
Confuses right and left	☐	☐	☐	_____
Sloppy handwriting/frequent erasing	☐	☐	☐	_____
Awkward pencil grip	☐	☐	☐	_____

	Often	Sometimes	Never	Details
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? _____

Is the patient 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 ☐

SCREEN TIME/LEISURE TIME ACTIVITIES

How many hours per day are spent on a screen or device (television, tablet, computer, laptop, video games, cell phone)? _____

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 Parent(s) ☐ Adoptive Parent(s) ☐ 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 evaluation:

_____

_____

_____

_____

_____

_____

_____

RELEASE OF INFORMATION AND INSURANCE FILING

IT IS OFTEN BENEFICIAL FOR US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH OTHER PROFESSIONALS INVOLVED IN YOUR CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I authorize the release of medical information to 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 visual condition or for the processing of insurance claims. This authorization shall be considered valid for the duration of my treatment. I consent that typing my name below will act as my signature.

_____ _____

Signature of patient or authorized representative 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 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. We request a minimum of 24 hour notice if you are unable to keep this appointment.

Missed appointment fee is $75 without 24 hour notice.

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

Thank you.

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