266 Lamp & Lantern Village, Town & Country, MO 63017 ph (636)527-8877, fax (636)527-8897, IL (618)444-8570, www.drdibler.com

CHILDRENS VISION QUESTIONNAIRE - EXTENDED

Appointment: Day _____ Date _____ Time _____
Patient's Name: _____

GENERAL INFORMATION
How did you find out about the office of Lisa B. Dibler, O.D.?_____

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

Child's Full Name: _____ Called_____Male _____ Female _____
Birth Date: _____Age: _____years / months. Is your child especially afraid of doctors? _____
Name and address of school: _____
Grade: _____ Teacher: _____ School Nurse: _____ Principal: _____
Child's dominant hand (circle): right or left? Has guidance been given in use of hand? Yes ☐ No ☐

RESPONSIBLE PERSON INFORMATION
Name: _____ Father's Name_____ Mother's Name _____
Home Address: _____ City:_____ Zip: _____
Home Phone: _____ Pager: _____ Work Phone: _____
Father Address: _____ Employer/Occupation_____
Mother Address: _____ Employer/Occupation _____
Major Medical Insurance? Yes ☐ No ☐ Name of Insured: _____
Name of carrier? _____D.O.B _____ Policy #: _____
Social Security Number: _____ Child's SSN :_____

PRESENT SITUATION
Why do you feel your child needs a visual evaluation? _____
_____
_____
_____

How long has this problem/difficulty been observed? _____
Who first noticed this problem? _____ Was the onset sudden or gradual? _____
Have you noticed any differences in this child compared to other children or siblings? _____
_____
Is there any evidence from the school or other tests that indicates some visual malfunction may be present? Yes ☐ No ☐
If yes, what? _____
_____

FAMILY ENVIRONMENT

Parents: ( )married ( )separated ( )divorced ( )birth parents ( )step parents ( )foster parents ( )adopted parents
Please list the names and birth dates of your family:

	NAME	AGE	M/F	STEP/ADOPTED?	SCHOOL DIFFICULTY?
Father					
Mother					
Sibling					
Sibling					
Sibling					
Sibling					

Number of household moves in child's lifetime? _____ Comments? _____
Does your child spend time with any other person, not in the home? Yes ☐ No ☐
Please explain: _____
Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? Yes ☐ No ☐
If yes, at what age: _____
Is family life stable at this time? Yes ☐ No ☐
If no, please explain: _____
How does your child get along with:
Parents/other caretakers? _____
Siblings? _____
Classmates in school? _____
Playmates at home? _____

MEDICAL HISTORY

Pediatrician's Name: _____ Date of Last Evaluation: _____
Child's current state of health: _____
Medications currently using, including vitamins and supplements: _____
_____
For what condition(s)? _____
_____

Any reactions to immunization(s)? Yes ☐ No ☐ If yes, explain: _____

List illnesses, bad falls, high fevers, accidents, broken bones, hospitalizations, etc.:

Age	Severe	Mild	Complications

Is your child generally healthy? Yes ☐ No ☐
If no, explain: _____
Are there any chronic problems like ear infections, asthma, hay fever, allergies, skin conditions? ____
If yes, please list: _____

Has a neurological evaluation been performed? Yes ☐ No ☐ By whom? _____
Address: _____ Phone: _____ When? _____
Results and recommendations: _____

Has a psychological evaluation been performed? Yes ☐ No ☐ By whom? _____
Address: _____ Phone: _____ When? _____
Results and recommendations: _____
_____

Has an occupational therapy evaluation been performed? Yes ☐ No ☐ By whom? _____
Address: _____ Phone: _____ When? _____
Results and recommendations: _____
_____
List any diagnosis that your child has received to date: _____

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

	Patient	Family	Who		Patient	Family	Who
Diabetes	☐	☐	_____	High Blood Pressure	☐	☐	_____
Eye turn	☐	☐	_____	Learning Disability	☐	☐	_____
Chromosomal Imbalance	☐	☐	_____	Amblyopia (lazy eye)	☐	☐	_____
Glaucoma	☐	☐	_____	Multiple Sclerosis	☐	☐	_____
Psychiatric disorders	☐	☐	_____	Epilepsy or Seizures	☐	☐	_____
				Other	☐	☐	_____

If other, please explain: _____
_____

DEVELOPMENTAL HISTORY
Full-term pregnancy? Yes ☐ No ☐
Did the mother experience any health problems during the pregnancy? Yes ☐ No ☐
If yes, explain: _____
Normal birth? Yes ☐ No ☐
Any complications before, during or immediately following delivery? Yes ☐ No ☐
If yes, explain: _____
Birth weight: _____ Apgar scores @ birth: _____ After 10 minutes: _____
Were forceps used? Yes ☐ No ☐
Breast fed? _____ How long? _____ Bottle fed? _____ How long? _____

Was there ever any reason for concern over your child's general growth or development?
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? _____
If not, describe: _____
At what age did your child walk? _____
Was child active? Yes ☐ No ☐
Speech: First words: _____ At what age: _____
Was early speech clear to others? Yes ☐ No ☐
Is speech clear now? Yes ☐ No ☐

VISUAL HISTORY

Has your child's vision been previously evaluated? Yes ☐ No ☐
If so, Doctor's Name: _____ Date of last evaluation: _____
Reason for examination: _____
Results and recommendations: _____
Were glasses, contact lenses, or other optical devices recommended? Yes ☐ No ☐
If yes, what? _____
Are they used? Yes ☐ No ☐ If yes, when? _____
If not used, why not? _____
Members of the family who have had visual attention and the reason:

Name	Age	Visual Situation
_____	____	_____
_____	____	_____
_____	____	_____

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? _____
Child's reaction to fatigue? sag ☐ irritable ☐ other ☐
Child's reaction to tension? avoidance ☐ irritable ☐ other ☐ _____
Does your child say and/or do things impulsively? Yes ☐ No ☐
Is your child in constant motion? Yes ☐ No ☐
Can your child sit still and concentrate for long periods of time? ____ When? _____

Does your child report any of the following?:	**Yes**	**No**	**If yes, when?**
Headaches	☐	☐	_____
Blurred vision / focus goes in and out	☐	☐	_____
Double vision	☐	☐	_____
Eyes hurt	☐	☐	_____
Eyes tired	☐	☐	_____
Words move around on the page	☐	☐	_____
Motion sickness / car sickness	☐	☐	_____
Dizziness	☐	☐	_____

List any other complaints your child makes concerning his/her vision: _____

_____

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING:

	Yes	No	If yes, when?
Eyes frequently reddened	☐	☐	
Frequent eye rubbing	☐	☐	
Frequent sties	☐	☐	
Frowning	☐	☐	
Bothered by light	☐	☐	
Frequent blinking	☐	☐	
Closing or covering one eye	☐	☐	
Difficulty seeing distant objects	☐	☐	
Head close to paper when reading or writing	☐	☐	
Avoids reading	☐	☐	
Prefers being read to	☐	☐	
Tilts head when reading	☐	☐	
Tilts head when writing	☐	☐	
Moves head when reading	☐	☐	
Confuses letter or words	☐	☐	
Reverses letter or words	☐	☐	
Confuses right and left	☐	☐	
Skips, rereads or omits words	☐	☐	
Loses place while reading	☐	☐	
Vocalizes when reading silently	☐	☐	
Reads slowly	☐	☐	
Uses finger as a marker	☐	☐	
Poor reading comprehension	☐	☐	
Comprehension decreases over time	☐	☐	
Writes or prints poorly	☐	☐	
Writes neatly but slowly	☐	☐	
Does not support paper when writing	☐	☐	
Awkward or immature pencil grip	☐	☐	
Frequent erasures	☐	☐	
Tires easily	☐	☐	
Difficulty copying from chalkboard	☐	☐	
Difficulty recognizing same word on different page	☐	☐	
Poor word attack skills	☐	☐	
Difficulty with memory	☐	☐	
Remembers better what hears than sees	☐	☐	
Responds better orally than by writing	☐	☐	
Seems to know material, but does poorly on tests	☐	☐	
Dislikes / avoids near tasks	☐	☐	
Short attention span / loses interest	☐	☐	
Poor large motor coordination	☐	☐	
Poor fine motor coordination	☐	☐	
Difficulty with scissors / small hand tools	☐	☐	
Dislikes / avoids sports	☐	☐	
Difficulty catching / hitting a ball	☐	☐	

SCHOOL

Age at time of entrance to: Pre-school _____ Kindergarten _____ First Grade _____
Does your child like school? Yes ☐ No ☐
Specifically describe any school difficulties: _____

_____
Has your child changed schools often? Yes ☐ No ☐
If yes, when? _____
Has a grade been repeated? Yes ☐ No ☐
If yes, which and why? _____
Does your child seem to be under tension or extreme pressure when doing school work? Yes ☐ No ☐
Has your child had any special tutoring, therapy, and/or remedial assistance? Yes ☐ No ☐
If yes, when? _____
Where and from whom? _____
How long? _____
Results: _____
Does your child like to read? Yes ☐ No ☐
Voluntarily? Yes ☐ No ☐
Does your child read for pleasure? Yes ☐ No ☐
What? _____

What is your child's attitude toward reading, school, his/her teachers, other youngsters? _____

_____
Overall schoolwork is: above average ☐ average ☐ below average ☐
WHICH SUBJECTS ARE:
Above average: _____
Average: _____
Below average: _____
Does your child need to spend a lot of time/effort to maintain this level of performance?
Yes ☐ No ☐
How much time on average does your child spend each day on homework assignments? _____
To what extent do you assist your child with homework? _____

Do you feel your child is achieving up to potential? Yes ☐ No ☐
Does the teacher feel your child is achieving up to potential? Yes ☐ No ☐ Comments _

_____

_____

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Does child watch TV? _____ How much? _____ How often? _____ Viewing distance? _____
Does your child spend time using computer/video games? Yes ☐ No ☐
If yes, how much? _____ How often? _____ Viewing distance? _____
What other activities occupy your child's leisure time? _____
Are there any activities your child would like to participate in, but doesn't? _____
Please explain: _____

_____

NUTRITIONAL INFORMATION

Current Diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Does your child: Like sweets ☐ or crave sweets ☐ If yes, what types?_____

Child's favorite foods_____ Does child like milk? _____

Typical breakfast, lunch and dinner: _____

Food Allergies: _____Comments:_____

Is your child active? Yes ☐ No ☐ Comments: _____

Are there periods of

very high energy? Yes ☐ No ☐

very low energy? Yes ☐ No ☐

Explain: _____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON: _____

IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL/IMPORTANT IN OUR TREATMENT OF YOUR CHILD?

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 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 Lisa B. Dibler, O.D., LLC when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I authorize Lisa B. Dibler, O.D., LLC to exchange verbal or written information with my child's school, teachers 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.

_____ _____

Signature of Parent or Guardian Date

I hereby give my permission to Lisa B. Dibler, O.D., LLC 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 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.

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

THANK YOU.

SINCERELY,

LISA B. DIBLER, O.D.