

SNOWY RANGE VISION CENTER
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Child's Full Name _____ Nickname _____
 Birthdate _____ Age now _____
 Parents Name _____
 School _____ Grade _____
 Teacher's Name _____

A. Present Situation

1. Why do you feel your child needs a visual examination? _____

2. Does your child complain of his/her vision? _____

3. Who first noted the visual difficulties? _____ When? _____
4. Did this difficulty occur suddenly? _____ Did it seem related to illness,
 accident, or any other related occurrence? _____
5. Request for evaluation initiated by: _____
 Name _____ Position _____
 Address _____ Phone _____
6. Have you noticed anything in home behavior to suggest difficulties? _____
 Describe briefly: _____

7. Are glasses being worn? Yes _____ No _____ How long? _____
 Why were glasses prescribed: (Check reason)
 Distant vision: Blur _____ Headaches _____ Eye turned _____
 Near vision: Comfort _____ Blur _____ Double _____ Not known _____
 Other reasons: _____
 How often have changes been made? _____
 When were present glasses prescribed? _____
 Are they comfortable? Yes _____ No _____ Explain _____
 Does s(he) wear them all the time? Yes _____ No _____ Explain _____
8. Has your child ever participated in a visual training program? _____
9. Has your child ever had any operations on his/her eyes? Yes _____ No _____
 Explain _____
10. Have "drops" ever been used in the examination of your child? _____
 What were the reactions or effects of the "drops" that you could
 observe? _____
11. Does your child report any of the following, and if so, when?

	YES	NO	WHEN
A. headaches	_____	_____	_____
B. blur vision at far seeing	_____	_____	_____
C. blur vision when reading	_____	_____	_____
D. double vision	_____	_____	_____
E. eyes "hurt" or "tired"	_____	_____	_____
F. nausea or dizziness	_____	_____	_____
G. car sickness	_____	_____	_____
H. bothered by light	_____	_____	_____
I. spots before the eyes	_____	_____	_____

12. Have you or anyone else ever noted the following, and if so, when?

	YES	NO	WHEN
A. one eye turn in or out at any time	_____	_____	_____
B. reddened eyes or lids	_____	_____	_____
C. eyes tear excessively	_____	_____	_____
D. encrusted eyelids	_____	_____	_____
E. frequent styes on lids	_____	_____	_____
F. excessive eye rubbing	_____	_____	_____
G. excessive blinking	_____	_____	_____
H. holding reading close	_____	_____	_____
I. closing one eye frequently	_____	_____	_____
J. covering one eye frequently	_____	_____	_____
K. tilting head when reading	_____	_____	_____
L. inability to see distant objects	_____	_____	_____
M. squinting	_____	_____	_____
N. bumping into objects	_____	_____	_____
O. poor general coordination	_____	_____	_____
P. head turns as reads across the page	_____	_____	_____
Q. loses place when reading	_____	_____	_____
R. needs finger or marker to keep place	_____	_____	_____
S. repeats or omits words or lines while reading	_____	_____	_____
T. confuses left-right directions	_____	_____	_____
U. reverses words, letters, or numbers while reading	_____	_____	_____
V. short attention span while reading	_____	_____	_____
W. fatigues easily	_____	_____	_____
X. poor posture	_____	_____	_____
Y. writes crookedly, poorly spaced: Cannot stay on ruled lines	_____	_____	_____
Z. comprehension reduces as reading continued; loses interest too quickly	_____	_____	_____
AA. difficulty copying from chalkboard	_____	_____	_____
BB. difficulty with spelling	_____	_____	_____

B. GENERAL HEALTH

1. Illness and age at time of each
 - a. _____ age _____ severity _____
 - b. _____ age _____ severity _____
 - c. _____ age _____ severity _____

Comments: _____

2. Allergies (frequency and treatment)? _____
3. Is your child presently under a physician's care? _____ Purpose? _____
Is s(he) receiving any medication at present? _____ Purpose? _____
4. Does your child become feverish easily? _____ When? _____
Is it a high fever? _____ What & when was the highest fever? _____
5. Has s(he) ever had any injuries involving the eyes, head, neck, or

C. GENERAL BEHAVIOR

1. Which hand does your child prefer to use? _____
Was handedness ever changed? YES ___ NO ___ Explain _____
2. What are your child's special interests/hobbies? _____
3. Is play very active or very quiet? _____
4. Is your child good with hands (for present age)? _____
5. Do erector sets, cutting, coloring, and puzzles hold attention? _____
6. Can s(he) throw and catch a ball? _____
7. Does your child get along with adults? ___ Other Children? _____
8. Is your child observant? _____ Is your child distractible? _____
9. Does your child like books and magazines? ___ Does s(he) like to be read to? ___ When do you do the most reading to your child - nap time, bed time, or other? _____
10. Give a brief thumbnail sketch of your child personality: _____

D. SCHOOL HISTORY

1. At what age did your child enter first grade? Yrs. _____ Mo. _____
How long in Kindergarten? _____ Nursery school? _____
2. Does s(he) attend school regularly or has s(he) had frequent absences? _____
3. Has s(he) changes schools frequently? YES ___ NO ___ When & Why? _____
4. How is the child getting along in school? _____
What is his/her favorite subjects? _____
Which subjects present difficulties? _____
When was difficulty first noted? _____
5. Has s(he) ever repeated a grade? _____ Why? _____
6. What is your child's attitude toward school, reading, teachers, and other youngsters? _____
7. Has s(he) had any special tutoring and remedial work? YES _____
NO _____ When and from whom? _____
8. Has the teacher reported anything about your child's school work? _____

E. DEVELOPMENTAL HISTORY

- Source of data: baby book ___ other records ___ memory ___
1. Birth data: Normal ___ Premature ___ Overdue ___
Instrument Delivery ___ Caesarian Section ___ Injury ___
Complications ___ Weight ___
 2. Was your child active in crib & since? _____
 3. Was your child an "easy" or a "difficult" baby? ___ (Good or Fussy)
Any colic or early management problems? _____
 4. Did s(he) have a play pen? ___ How often used? _____
Did s(he) have a walker? ___ How often used? _____
 5. Was movement ever restricted by a cast or brace? _____

PERFORMANCE	AVERAGE	DATA	REMARKS
I. Location			
A. Sits momentarily alone	6-8 mos		
B. Crawl	7-9 mos		
C. Stand Alone	12-15 mos		
D. Walk Alone	12-15 mos		
II. Elimination			
A. Established bowel control	12-24 mos		
B. Established bladder contro	2-3 yrs		
III. Dressing			
A. Buttons Clothes	4 yrs		
B. Laces shoes	5 yrs		
IV. Speech			
A. Sounds			
1. Syllables	6 mos		
2. da-da, etc.	9 mos		
B. Words			
2 words	12 mos		
4 words	15 mos		
C. Sentences			
Short sentences	24 mos		
Gives full name	30 mos		

Check one reason for this appointment:

Standard vision & eye health exam _____ Exam for underachieving child _____
 Exam for contact lenses _____ Exam requested by other professional _____
 Who will be the responsible party for payment? _____
 Method of payment preferred: CASH CHECK MC BAC

As you complete this history questionnaire, you will recognize the thoroughness with which your child's problem will be considered. The office examination will take up enough time to permit a very complete optometric investigation of the problem. Your child's future deserves the fullest consideration that you as parents and we here in the office can provide. If you will consent to our sending a similar questionnaire to your child's teacher and also sending him or her a report of your child's visual status so that s(he) may better understand your child's visual needs as they relate to the classroom, please sign below.

Signature of parent or guardian _____