

**Indiana University School of Optometry Pediatric/Binocular Vision Services**  
**Confidential Patient Survey**

Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Mo. Day Yr.

Child's Full Name \_\_\_\_\_  
 Last, First, Middle

Birth date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Mo. Day Yr.

Child lives with:  Both Parents  Natural Parent(s)  Adoptive Parent(s)  
 Father  Mother  Other \_\_\_\_\_

**MEDICAL INFORMATION**

Child's Medical Doctor: \_\_\_\_\_

Address \_\_\_\_\_

Phone number \_\_\_\_\_

Does your child currently have any of the following problems?	Yes	No	If Yes, Please explain:
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Problems (shortness of breath, wheezing, cough)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Problems (heartburn, abdominal pain, diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary Problems (pain or discomfort, blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Problems (rashes, excessive dryness)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal Problems (muscle aches, joint pain, swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Problems (numbness, weakness, headaches, paralysis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric Problems (depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic fever, unexpected weight loss/gain, fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat Problems (hearing loss, sinus problems, sore throat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine Problems (diabetes, thyroid problems)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Has your child or immediate family member (parent, grandparent, sibling) ever had any of the following conditions?

Child/Family	Child/Family	Child/Family	Child/Family
Birth Defects ____/____	Retinal detachment ____/____	Migraines ____/____	Cancer ____/____
Cataract ____/____	Retinal disease ____/____	Seizures ____/____	Diabetes ____/____
Glaucoma ____/____	Blood disorders ____/____	Mental Retardation ____/____	Thyroid disease ____/____
Lazy eye ____/____	Heart disease ____/____	Mental disorders ____/____	Liver Disease ____/____
Crossed eye ____/____	Tuberculosis ____/____	Emotional disorder ____/____	Learning issues ____/____
Blindness ____/____	HIV/AIDS ____/____	Arthritis ____/____	Hospitalized ____/____

1. Were there any problems during the birth of your child?  Yes  No  
 During pregnancy?  Yes  No  
 At delivery?  Yes  No  
 Immediately following birth?  Yes  No

If YES, please explain: \_\_\_\_\_  
 \_\_\_\_\_

2. Your child was delivered at \_\_\_\_\_ weeks (number of weeks) Birth weight: \_\_\_\_ lbs. \_\_\_\_ oz.

3. Is your child currently under a doctor's care?  Yes  No If YES, please explain: \_\_\_\_\_  
 \_\_\_\_\_

4. Does your child take any medication(s) at this time, including non-prescription?  Yes  No  
 If YES, name of medication(s): \_\_\_\_\_  
 \_\_\_\_\_

5. Does your child have a history of allergies, (to medications or environmental)?  Yes  No  
 If YES, explain: \_\_\_\_\_

**VISUAL HISTORY:**

1. Has your child had any previous vision care?  Yes  No  
If YES, please complete the following:

VISION CARE	AGE	REASON	RESULTS
GLASSES			
EYE PATCHING			
EYE MEDICATION			
EYE SURGERY			

2. If your child currently wears glasses, when are they worn? \_\_\_\_\_  
Does your child wear them without constant supervision?  Yes  No
3. Does your child complain of:
- Frequent headaches?  Yes  No If YES, when? \_\_\_\_\_
- Blurred vision or eyes "stinging"?  Yes  No If YES, when? \_\_\_\_\_
- Eyes "hurt" or feel "tired"?  Yes  No If YES, when? \_\_\_\_\_
- Seeing double?  Yes  No If YES, when? \_\_\_\_\_
- Blur at distances (like movie or chalkboard)?  Yes  No If YES, when? \_\_\_\_\_
4. Does your child frequently close or cover one eye?  Yes  No If YES, when? \_\_\_\_\_
- Do bright lights bother your child?  Yes  No If YES, when? \_\_\_\_\_
- Are there frequent sties?  Yes  No If YES, which eye?  L  R
- Does he/she blink excessively?  Yes  No If YES, when? \_\_\_\_\_
5. Please leave blank if the question does not apply to your child
- Does your child reverse words or letters in reading and spelling?  Yes  No
- Does he/she skip words or reread words or lines?  Yes  No
- Does he/she tilt head while reading?  Yes  No
- Does he/she move head while reading?  Yes  No
- Does he/she frown or squint at reading or TV?  Yes  No
- If permitted, does he/she use finger or a marker to follow words?  Yes  No
- Does he/she hold books too closely while reading?  Yes  No

**HOME BEHAVIOR**

1. All children exhibit, to some degree, the kinds of behavior listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared with other children his or her age.

- Hyperactivity (high activity level)
- Does not listen when being spoken to
- Poor attention span
- Impulsiveness (poor self control)
- Poor memory
- Dislike of reading or other near tasks

2. What are your child's usual play activities? \_\_\_\_\_  
\_\_\_\_\_

3. Does your child like books and magazines?  Yes  No  
Does he/she like to be read to?  Yes  No

**IF YOUR CHILD ATTENDS SCHOOL PLEASE COMPLETE THE FOLLOWING SECTION**

**SCHOOL INFORMATION:**

1. Did your child attend preschool  Yes  No  
Date entered first grade: \_\_\_\_\_ (mo.) \_\_\_\_\_ (yr.) Age \_\_\_\_\_ Current grade in School \_\_\_\_\_

2. Does your child enjoy school?  Yes  No  
Is school attendance regular?  Yes  No If NO, why? \_\_\_\_\_  
\_\_\_\_\_

3. Has your child ever repeated any grade?  Yes  No

4. In your opinion, what is your child's easiest subject? \_\_\_\_\_ Hardest subject? \_\_\_\_\_

5. Has your child had any remedial work?  Yes  No  
If YES, when? \_\_\_\_\_ In what subject? \_\_\_\_\_ From whom? \_\_\_\_\_

6. Has your child ever had: Educational testing  Yes  No  
Psychological or audiological testing  Yes  No  
If YES, when? \_\_\_\_\_ Explain: \_\_\_\_\_  
\_\_\_\_\_

7. Is your child receiving any special education services?  Yes  No If YES, what is the service?  
\_\_\_\_\_  
\_\_\_\_\_

Parent's/Guardian's Signature _____	Date _____
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Reviewed:	Date	Intern	Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____