.

PENROSE EYECARE

PARENT QUESTIONNAIRE

CHILDS NAME: ……. DOB: …….

ADDRESS: …… ……. PHONE: …….
……
……..

SCHOOL: ……..…….. GRADE: …….

TEACHER(S): ……...

PARENT'S NAMES OCCUPATIONS:
…….. ……
…….. ……

ENTERING COMPLAINT/MAJOR CONCERN:

1 In your own words, please state briefly your main concern and the main problem your child is having
…… ……
……
……
……
…….

2 Who first noted the visual difficulties? ……..……...
When? ……

3 Whose idea was it that you come in for an evaluation? (Teacher, School, Nurse, Doctor)? …….

VISUAL HISTORY:

1 Has there been previous visual care? ..... Please describe in detail (include any information about glasses, patching, vision therapy, medication or surgery)……..……
……
……

2 Does your child report or have you noticed any of the following?

……. Skips and rereads words or letters.

……. Complains of blurred vision during reading or writing.

……. Complains of headaches associated with visual tasks.

……. Complains of print "running together"/"jumping."

……. Reports sensation of eyes “not working together.”

……. One eye turns in or out, up or down at any time.

……. Experiences unusual fatigue after visual concentration.

……. Reports pain around or in the eyes at anytime.

……. Reddened eyes or lids.

……. Excessive tearing of eyes, or rubs eyes frequently.

……. Blinks excessively.

……. Frowns, scowls, or squints with visual tasks.

……. Tilts or turns head while reading.

……..Closes or covers one eye during visual tasks.

……. Moves head forward/back while looking at distance

……. Avoids close work.

……. Holds books too closely.

……. Reversals when reading (was/saw, on/no) on writing

……. Uses finger as a marker when reading.

……. Transposition of letters or numbers (21 for 12).

……. Poor printing or handwriting.

……. Difficulty in copying from blackboard to paper.

DEVELOPMENTAL HISTORY:

1 Were there any complications with pregnancy or at birth? If yes, please explain: ……

2 Was the child born prematurely? …… If yes, what was the length of the pregnancy? ……

3 Childs birth weight: ……

4 Was there any use of alcohol, drugs, medication, or cigarettes during pregnancy? ..... ……. If yes, please explain: ……
……

5 At what age did your child crawl on all fours? ……...

6 At what age could your child pull himself or herself up to chairs and tables? .....

7 At what age did your child walk? ……..

8 At what age did your child first make speech sounds? …….. When and what were his or her first words? ……..

9 Was speech clear? ……... Could others besides the family understand your child's early speech? ……

10 Is speech adequate now? ……..

11 Can your child dress himself or herself? ……. Button clothes? …….. Tie bows? ……. Zip zippers? …….. Lace shoes? …….. Could he or she do these before entering school? ……...

12 Did the child have any early behavioral problems (temper tantrums, self-destructive behavior, difficulty sleeping, etc) If yes please explain:
……
……

GENERAL HEALTH AND BEHAVIOR:

1 Have there been any severe childhood illnesses, high fever, injury, or physical impairment? …….. If yes, please explain:
……
……
…….

2 Has the child had any ear infections? ……. If yes, please indicate how often and whether any treatment was received.
……
……

3 Does the child have any allergies to food, medication, or environmental allergies? …….. If yes, please indicate to what and whether he or she is receiving any treatment: ……
……

4 Has your child ever had a neurological evaluation? ……. If yes, please indicate when and the results: ……
……

5 Does your child have a history of epilepsy or seizures? ……..

6 .What medications (such as penicillin or sulfonamide drugs) have been given and for what? ……...
……

7 Has your child ever had a reaction to a medication? ……... If yes, please describe: …….....
……

8 Is your child receiving any medication at present? ……Purpose?
…… ……

9 Has your child ever had a speech and language evaluation or therapy? ……...If yes, please indicate when and the results: ……..
……..

10 . Does your child have frequent periods of extreme fatigue? ……. If yes, when?……

11 Does fatigue result in sluggishness, excitability, or irritability? .....

12 Does your child exhibit any tensional behavior such as nail biting, eye blinking or rubbing, tantrums, tongue chewing or lip biting, etc? If so, when? ……..……..
……
Do these tensional behaviors seem related to school, schoolwork, or television?
…...……

13 What are your child's special interests? ……...
……

14 Is your child good with his or her hands (for present age)? ……. Is block play good? ……. Do building sets, puzzles, colouring, and cutting hold attention?
…….……

15 Does he or she like to participate in sports activities? ……..

16 Does your family read a lot? ……

17 Is there a family history of significant reading, writing, or spelling difficulties? …..
Who? ……
Describe: ……...
……

18 Is there a family history of hyperactivity, attention problems, or speech difficulties? ..... Who? ……
Describe: ……...
……

EDUCATION INFORMATION:

1 At what age did you child begin preschool? …….. Kindergarten? …….
Grade 1. ……
2 Has your child ever repeated a grade? ……. If yes, which one(s)?
……
……
3 Has your child had any evaluations (psychological, special educational, etc.) at school? ……. If yes, indicate when and the results: ……
……
4 Does your child receive any special services from the school (speech and language, reading remediation, etc.)? ……. If yes, indicate type and how often:
……...
……
5 Is your child in a specialized classroom setting (self-contained, resource, etc.)?
…...
If yes, indicate the type.
……
6 How is your child getting along in school? ……..
In your opinion, what is his or her best subject? ……..
Easiest subject? ……Hardest subject? …….
If there is difficulty at school, what do you think is the reason?

……..
……

7 Has the teacher reported anything about your child's school work?
……
……

8 Please indicate yes or no for the following:
Yes/No

……. Does the child like school?

……. Does the child like his or her teacher?

……. Is the school satisfied with the child's performance?

……. Does your child attend school regularly?

……. Is his or her school performance up to potential?

……. Is the child attending the grade level expected for his or her age?

……. Does this child read as well as others in the same grade?

……. Or as well as brothers and sisters?

Please indicate any other additional information that you believe may be helpful: ...
……
……
……