J. Robert Walesby, O.D.,F.C.O.V.D.
Shereé Wright, O.D.

WALESBY VISION CENTER
"Where Vision Is More Than Just 20/20"

Nicholas Thomas, O.D., F.C.O.V.D.
Clinical Director of Vision Therapy

CHILDREN'S VISION QUESTIONNAIRE - EXTENDED

*Please fill out this questionnaire carefully & completely & submit it to our office **FOUR BUSINESS DAYS PRIOR** to your Screening or Work-Up appointment. Thank you.*

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

How did you hear about us?

- ☐ Referred by_____ Reason: _____
- ☐ Internet (specify)_____
- ☐ Insurance (Carrier) _____
- ☐ Yellow Pages/ White Pages
- ☐ Television
- ☐ Drive by
- ☐ Other (specify)_____

GENERAL INFORMATION

Child's Full Name:_____ Male ☐ Female ☐
Birth Date:_____ Age:_____years_____months
Home Address:_____ City:_____ Zip: _____
Primary Phone: ( )____-_____ Alt. Phone:( )_____ Fax #:( )____-_____
Occupation Father/Guardian:_____ Work #: ( )_____-_____
Occupation Mother/Guardian:_____ Work #: ( )_____-_____
Email Father:_____ Mother: _____

FAMILY MEMBERS

NAME

Father/Guardian:_____ Birth Date:_____
Mother/Guardian:_____ Birth Date:_____
Sibling:_____ Birth Date:_____
Sibling:_____ Birth Date:_____
Sibling:_____ Birth Date:_____
Sibling:_____ Birth Date:_____

SCHOOL INFORMATION

Name of school:_____ Location:_____
Grade:_____ Teacher 1:_____ Teacher 2:_____
Guidance Counselor:_____ Principal:_____
Child's dominate hand: right ☐ left ☐ Has guidance been given in use of hand? Yes ☐ No ☐

2510 W Waters Ave • Tampa, FL 33614 • (813) 915-0755 • Fax: (813) 915-0704
24444 State Road 54 • Lutz, FL 33559 • (813) 345-8544 • Fax: (813) 406-4424

MEDICAL HISTORY

Pediatrician:_____ Date of Last Evaluation:_____
Reason for Visit: _____
Results and recommendations:_____
_____
Child's current state of health:_____
Current medications, including vitamins and supplements:_____
_____
For what condition(s): _____

Are immunizations up to date? Yes ☐ No ☐ Opted Out ☐
Any reaction to immunizations: Yes ☐ No ☐
If yes, explain:_____

List illnesses, injuries, head trauma, high fevers, etc.:

Age	Severe/Mild	Complications
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____

Are there any chronic problems (ear infections, asthma, hay fever, allergies, etc.)? Yes ☐ No ☐
If yes, please list: _____
Has a neurological evaluation been performed? Yes ☐ No ☐ **If yes, Please Provide a Copy**
By whom?_____ Results and recommendations: _____
_____
Has a psychological evaluation been performed? Yes ☐ No ☐ **If yes, Please Provide a Copy**
By whom?_____ Results and recommendations: _____
_____
Has an occupational therapy evaluation been performed? Yes ☐ No ☐ **If yes, Please Provide a Copy**
By whom? Results and recommendations: _____
_____

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

	Patient	Family	Who		Patient	Family	Who
Diabetes	☐	☐	_____	High Blood Pressure	☐	☐	_____
"Cross" or "Wall" eye	☐	☐	_____	Learning Disability	☐	☐	_____
Chromosomal Imbalance	☐	☐	_____	Amblyopia (lazy eye)	☐	☐	_____
Glaucoma	☐	☐	_____	Multiple Sclerosis	☐	☐	_____
				Epilepsy or Seizures	☐	☐	_____
				Other	☐	☐	_____

If other, please explain: _____
_____

NUTRITIONAL INFORMATION

Current Diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Does he/she: Like sweets ☐ and/or crave sweets ☐
If yes, what type(s)? _____
Is he/she physically active? Yes ☐ No ☐ Normal ☐ Extreme ☐
Are there periods of very high energy? Yes ☐ No ☐ periods of very low energy? Yes ☐ No ☐
Explain: _____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes ☐ No ☐ _____weeks early
Did the mother experience health problems during the pregnancy? Yes ☐ No ☐
If yes, explain: _____
Method of delivery: Cesarean Section ☐ Vaginal ☐
Complications before, during, or following delivery? Yes ☐ No ☐
If yes, explain: _____
Birth weight:_____lbs_____oz Apgar scores @ birth:_____After 10 minutes: _____
Were forceps used? Yes ☐ No ☐ Was a Vacuum Extraction used? Yes ☐ No ☐
Was there reason for concern over his/her general growth or development? Yes ☐ No ☐
If yes, explain: _____
Did he/she creep (stomach on floor)? Yes ☐ No ☐ age: _____
Did he/she crawl (on all fours)? Yes ☐ No ☐ age:_____
If not, describe: _____
At what age did he/she walk? _____
Was he/she active as an infant? Yes ☐ No ☐
Speech: First words:_____age: _____
Was speech clear to others? Yes ☐ No ☐ Is speech clear now? Yes ☐ No ☐

VISUAL HISTORY

Has his/her 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 worn currently? Yes ☐ Full time ☐ Distance only ☐ Near only ☐
No ☐ explain: _____

Members of the family who have had visual attention (i.e. surgery) and the reason:

Name	Age	Treatment/ Condition/ Procedure
_____	____	_____
		_____
_____	____	
_____	____	_____

PRESENT SITUATION

Why do you feel he/she needs a visual evaluation? _____
_____
_____
How long has this problem/difficulty been observed? _____
Has the presence of a visual malfunction been indicated by academic, psychological, occupational, or other tests? Yes ☐ No ☐
If yes, Please list and explain: _____
_____
_____
_____

Does he/she 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 he/she makes concerning his/her vision: _____

_____

_____

HAVE **YOU OR ANYONE** ELSE EVER NOTICED **ANY** OF THE FOLLOWING:

Appearance of Eyes

- ☐ Reddened eyes and/or lids
- ☐ Excessive tearing of eyes and/or rubbing eyes
- ☐ Excessively Blinking
- ☐ Frequent sties or pink eye

Refractive Error or Eye Focusing (Accommodation) Problem

- ☐ Excessive blinking during near tasks
- ☐ Frowns, scowls, or squints to see blackboard
- ☐ Avoids close work
- ☐ Fatigues easily during visual tasks
- ☐ Rubs eyes during or after visual activity
- ☐ Complains of blur while reading or writing
- ☐ Comprehension is poor when reading or performing near tasks

Eye Tracking (Ocular Motility) Problem

- ☐ Skips or rereads words or letters
- ☐ Rereads lines or phrases
- ☐ Confuses words with similar beginnings or endings
- ☐ Uses finger or marker when reading
- ☐ Loses place often when reading
- ☐ Repeatedly omits "small" words
- ☐ Excessive head movement/tilt when reading
- ☐ Difficulty hitting or catching a ball
- ☐ Dislikes or avoids sports
- ☐ Difficulty copying from chalkboard

Eye Teaming (Binocularity) Problem

- ☐ Complains of seeing double
- ☐ Covers or closes one eye
- ☐ One eye turns (in, out, up, or down)
- ☐ Tilts or turns head to one side
- ☐ Squints, closes, or covers one eye
- ☐ Complains of letters or lines "floating," "running together", or "jumping around"
- ☐ Reports confusion of what is seen

Visual Information-Processing Problem

- ☐ Confuses similar words
- ☐ Fails to recognize same word in next sentence or page
- ☐ Confuses minor likenesses and differences
- ☐ Makes errors in copying from chalkboard or reference book
- ☐ Difficulty following verbal instructions
- ☐ Difficulty completing assignments in time allotted
- ☐ Poor printing or handwriting
- ☐ Short attention span, distractible
- ☐ Says words aloud or moves lips while reading
- ☐ Reverses letters, numbers, or words
- ☐ Poor ability to recall what is read
- ☐ Poor eye-hand coordination
- ☐ Repeatedly confuses right-left directions
- ☐ Poor recall of visually presented tasks
- ☐ School performance not up to potential

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Does child watch TV?_____How much?_____How often?_____Viewing distance? _____
Does he/she spend time using computer/video games? Yes ☐ No ☐
If yes, how much?_____Frequently:_____Viewing distance: _____
What other activities occupy his/her leisure time? _____
Are there any activities he/she would like to participate in, but doesn't? _____
Please explain: _____

SCHOOL

Age at time of entrance to: Pre-school:_____Kindergarten:_____First Grade: _____
Does he/she like school? Yes ☐ No ☐
Does he/she like to read? Yes ☐ No ☐
Voluntarily? Yes ☐ No ☐ For pleasure? Yes ☐ No ☐
What:_____
What is his/her attitude toward reading, school, teacher(s), peers? _____
_____
Overall schoolwork is: above average ☐ average ☐ below average ☐
Specifically describe any school difficulties: _____
_____
Has he/she changed schools often? Yes ☐ No ☐ If yes, when? _____
Has a grade been repeated? Yes ☐ No ☐ If yes, which and why? _____
_____
Does he/she seem stressed or pressured when doing schoolwork? Yes ☐ No ☐
Has he/she had tutoring, therapy, and/or remedial assistance? Yes ☐ No ☐
If yes, from whom:_____Title: (OT, PT, SLP, etc.) _____
Currently attending? Yes ☐ No ☐ How long:_____How Often: _____
Address:_____
Results: _____

WHICH SUBJECTS ARE:

Above average: _____
Average:_____
Below average: _____
Does he/she spend excessive time/effort to maintain this level of performance? Yes ☐ No ☐
How much time (average) is spent on homework daily? _____
To what extent do you assist him/her with homework? None ☐ Partial ☐ Full ☐
Do you feel he/she is achieving up to full potential? Yes ☐ No ☐
Does his/her teacher feel that he/she is achieving up to full potential? Yes ☐ No ☐

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? drowsy ☐ irritable ☐ other ☐ _____
Child's reaction to tension/stress? avoidance ☐ irritable ☐ other ☐ _____
Does he/she say and/or do things impulsively? Yes ☐ No ☐
Is he/she in constant motion? Yes ☐ No ☐ Can he/she sit still for long periods of time? Yes ☐ No ☐

FAMILY AND HOME

With whom does child reside? Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐
Foster Parents ☐ Adoptive Parents ☐ Grandmother ☐ Grandfather ☐
Aunt ☐ Uncle ☐ Other Caregiver (please specify): _____

Does he/she spend time with any other person, not in the home? Yes ☐ No ☐
Please explain: _____

Has he/she experienced a family trauma (separation, divorce, chronic illness, parental loss, etc.)?
Yes ☐ No ☐ If yes, at what age: _____

Does he/she seem to have adjusted? Yes ☐ No ☐

Was counseling/therapy utilized? Yes ☐ No ☐
If yes, is it on-going? Yes ☐ No ☐

Is family life stable at this time? Yes ☐ No ☐
If no, please explain: _____

How does he/she get along with:
Parents/other caregivers: _____
Siblings: _____
Classmates: _____
Playmates at home: _____

Is there a family history of learning or developmental delay? Yes ☐ No ☐
Paternal: _____
Maternal: _____
Siblings: _____
Specify Condition: _____
_____
_____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD. INCLUDE INFORMATION THAT MAY BE HELPFUL IN HIS/HER TREATMENT/ DIAGNOSIS:

RELEASE OF INFORMATION AND INSURANCE FILING

IT IS OFTEN BENEFICIAL FOR US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH YOUR CHILDS PEDIATRICIAN, SCHOOL, 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 other health care providers or insurance carriers upon written request or recommendation of the WALESBY VISION CENTER when deemed necessary for treatment of his/her visual condition, or processing of insurance claims.

_____ _____

Parent's or Guardian's Signature Date

I do hereby give my permission to the WALESBY VISION CENTER to treat _____
(Child's Name)

_____ _____

Parent's or Guardian's Signature Date

This authorization is valid for the duration of treatment. Thank you for carefully completing this questionnaire. The information provided allows for a more efficient use of time, enabling us to perform a more comprehensive evaluation and better meet his/her specific visual needs.

If you have questions or concerns prior to your appointment, please do not hesitate to contact us.

A minimum cancellation notice of 48 hours is required, as previously agreed, or a $360 service charge will be processed. You may leave a voicemail at our office number at any time.

Please be prompt for the appointment, in order to maximize the time reserved to evaluate his/her visual status.

Your undivided attention is necessary during this evaluation; it is, therefore, advisable not to bring other children.

Your child may benefit from bringing something to occupy his/her time while you are in conference with the doctor.

Sincerely,

J. Robert Walesby, O.D., F.C.O.V.D.
Shereé Wright, O.D.

Nicholas Thomas, O.D., F.C.O.V.D.
Clinical Director of Vision Therapy

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