TEXAS STATE OPTICAL

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New Patient Pediatric Vision Questionnaire

Full Legal Name: _____ Date of Birth: ___ / ___ / ___ Age:_____
Name your child prefers to go by: _____

GENERAL INFORMATION
Were you referred to our office? Yes No
By whom? _____ His/Her profession: _____
Referral address: _____ Referral phone #: _____
May we update this referral source? Yes No

Name and address of school: _____
Grade: _____ Teacher's name: _____

Name(s) of parents or responsible guardian(s): _____
_____

PRESENT SITUATION
Why does your child need a vision evaluation? _____
_____

Do you have any concerns about your child's eyes/vision: Yes No
If yes please explain: _____
_____

Has the school/another professional expressed concern regarding your child's vision? If so, what concern: _____
_____

Vision History
Has your child had an eye exam before? Yes No
Doctor's name: _____ Date of last eye exam: _____
Were there significant results and/or recommendations? If so, explain: _____
_____

Does your child wear glasses or contact lenses? If so, what: _____
Are they used? Yes No If yes, when? _____
If not used, why not? _____

Has your child had eye surgery? Yes No
Procedure: _____ Surgeon: _____ Date: _____
Procedure: _____ Surgeon: _____ Date: _____

Has anyone in your child's family had any eye or vision problems?

Relationship	Eye Condition
_____	_____
_____	_____

MEDICAL HISTORY
Pediatrician's name and address _____
_____
May we update your pediatrician? Yes No

Were there any complications during the pregnancy and/or birth? Yes No
If yes, explain: _____
_____

Has your child had any significant illnesses, injuries, or hospitalizations? Yes No
If yes, explain: _____
_____
Has your child had any surgeries? Yes No
Procedure: _____ Surgeon: _____ Date: _____

List all medications your child takes: _____

Any environmental or medication allergies: Yes No
If yes, explain: _____

DEVELOPMENTAL HISTORY
Is your child developmentally delayed or have special needs? Yes No
If yes, explain: _____
_____
Is your child verbal or non-verbal? _____
Does your child use a wheelchair, walker, or other mobility aid? _____

Is your child enrolled in physical, occupational, speech, or other developmental therapies?
If yes, what? _____
Location and frequency? _____

HOBBIES
What does your child like to do for fun? _____