

VISUAL FUNCTIONING QUESTIONNAIRE

Please fill out this questionnaire carefully.

Please return it to our office prior to your appointment. THANK YOU.

Nutritional Information:

Current Diet: Excellent Good Fair Poor

Is your child active? Extremely Moderately Not very

Are there periods of *very* high energy or *very* low energy (please circle)?

Explain: _____

Developmental History:

Full-term pregnancy: Yes No

Any complications during pregnancy? Yes No if yes, please explain: _____

Normal birth: Yes No

Any complications immediately after delivery? Yes No if yes, please explain: _____

Low birth weight: Yes No

Was there ever any concern for the growth and development of your child: Yes No

if yes, please explain: _____

Vision Health History:

Has your child's vision been previously evaluated? Yes No

If so, Doctor's name and date of exam: _____

Results and recommendations from exam: _____

Were glasses, contact lenses or other optical devices recommended? Yes No

If yes, what was prescribed: _____ Are they being used? Yes No

If not, why not: _____

Present Situation:

Why do you feel your child needs a vision evaluation? _____

How long have you noticed this problem/difficulty? _____

Have there been any concerns raised by the school of teaching staff? Yes No

If yes, what: _____

DOES YOUR CHLD REPORT ANY OF THE FOLLOWING:

(please rank severity/frequency on a scale of 1 to 4; 4 being the most severe or frequent)

	<u>Yes</u>	<u>Ranking</u>
Headaches	<input type="checkbox"/>	_____
Blurred vision	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	_____
Eyes hurt	<input type="checkbox"/>	_____
Eyes feel tired	<input type="checkbox"/>	_____
Words move around on the page	<input type="checkbox"/>	_____
Motion sickness / car sickness	<input type="checkbox"/>	_____
Dizziness	<input type="checkbox"/>	_____

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING:

(please rank severity/frequency on a scale of 1 to 4)

	<u>YES</u>	<u>Ranking</u>		<u>YES</u>	<u>Ranking</u>
Moves head when reading:	<input type="checkbox"/>	_____	Skips, omits or re-reads words:	<input type="checkbox"/>	_____
Loses place while reading:	<input type="checkbox"/>	_____	Reads slowly:	<input type="checkbox"/>	_____
Uses finger as marker:	<input type="checkbox"/>	_____	Eyes frequently red:	<input type="checkbox"/>	_____
Frequent eye rubbing:	<input type="checkbox"/>	_____	Frequent blinking:	<input type="checkbox"/>	_____
Closing or covering one eye:	<input type="checkbox"/>	_____	Holds head close to paper:	<input type="checkbox"/>	_____
Focus goes in and out:	<input type="checkbox"/>	_____	Avoids reading:	<input type="checkbox"/>	_____
Prefers being read to:	<input type="checkbox"/>	_____	Tilts head when reading:	<input type="checkbox"/>	_____
Tilts head when writing:	<input type="checkbox"/>	_____	Confuses letter or words:	<input type="checkbox"/>	_____
Reverses letters or words:	<input type="checkbox"/>	_____	Difficulty copying from board:	<input type="checkbox"/>	_____
Vocalizes when reading silently:	<input type="checkbox"/>	_____	Confuses right and left:	<input type="checkbox"/>	_____
Poor reading comprehension:	<input type="checkbox"/>	_____	Decreased comprehension over time:	<input type="checkbox"/>	_____
Tires easily:	<input type="checkbox"/>	_____	Difficulty recognizing same word on different page:	<input type="checkbox"/>	_____
Difficulty with memory:	<input type="checkbox"/>	_____	Remembers better with listening than reading:	<input type="checkbox"/>	_____
Responds better orally than by writing:	<input type="checkbox"/>	_____	Seems to know material, but does poorly on tests:	<input type="checkbox"/>	_____
Dislikes/avoids near tasks:	<input type="checkbox"/>	_____	Short attention span/looses interest:	<input type="checkbox"/>	_____
Poor fine motor skills:	<input type="checkbox"/>	_____	Poor gross motor skills:	<input type="checkbox"/>	_____
Dislikes/avoids sports:	<input type="checkbox"/>	_____	Writes or prints poorly:	<input type="checkbox"/>	_____
Writes neatly but slowly:	<input type="checkbox"/>	_____	Does not support paper when writing:	<input type="checkbox"/>	_____
Awkward or immature pencil grip:	<input type="checkbox"/>	_____	Frequent erases:	<input type="checkbox"/>	_____

AUTHORIZATION FOR MEDICAL RECORD OR MATERIAL RELEASE:

Please list any immediate family member you would authorize us to release medical information or materials (i.e. glasses or contact lenses) to if you are unable to pick them up yourself.

I authorize; family member: _____ to pick any records or materials in my absence.

Initials: _____

FINANCIAL POLICY:

We are participating providers in Blue Cross Blue Shield of Illinois and Aetna. We may bill your medical insurance for any medically related eye emergencies or conditions that are treated during your visit.

We also accept VSP, EyeMed and Davis Vision which are used for routine eye exams, glasses and contact lenses. We require payment of any applicable co-pays at the time of the visit and we will provide an itemized receipt upon check out. We will strive to help you qualify for the maximum allowable benefit under your plan.

By signing below you authorize the release of any medical information to help us process your billing for your insurance company to maximize benefits and your reimbursement or for the referral to another doctor.

Please sign that you understand the above:

Signature: _____

Date: _____