Patient Name: _____Date Form Completed: _____

PATIENT HISTORY QUESTIONNAIRE – YOUNG ADULT (13-17 YEAR OLD)

As you complete this questionnaire, you will recognize the thoroughness and breadth of your teen's scheduled vision evaluation. The few minutes spent in answering all questions will allow Dr. Kadet or Dr. Pearson to better plan the flow of examination procedures and consider appropriate treatment options.

Thank you for the time and effort expended in completing our questionnaire. Leave blank or put "N/A" beside any questions not applicable to your teen. If you don't know the answer to a question, it is OK to say so.

PRESENT SITUATION, SYMPTOMS AND/OR CONDITIONS

What are the concerns prompting this vision evaluation?

_____

_____

_____

Is this appointment due to an accident? No □ Yes □
If yes, what type of an accident? _____
When did this accident occur? _____
Where did it occur? _____
Has your teen been diagnosed to have Traumatic Brain Injury? No □ Yes □
If yes, is an attorney representing him/her? No □ Yes □
If yes, attorney's name: _____
Attorney's phone number: _____

In your opinion, may vision be impacting academic performance?_____

How long have these concerns been observed?_____

Has your teen expressed concerns regarding vision?_____

Last Vision evaluation (year):_____ Doctor:_____ City:_____ State:___

Does your teen currently wear glasses?_____ Reason?_____ Year first prescribed:_____

Has your teen previously worn glasses, but not at present?_____ Reason for discontinued wear?____

_____

Does your teen currently wear contact lenses?_____

Has your teen previously received vision therapy?____ Reason:_____ Doctor:_____

Has your teen had eye surgery?_____ Reason:_____ Doctor:_____

Other family members receiving vision care services:

Name	Age	Visual Situation

_____

_____

_____

Patient Name: _____Date Form Completed: _____

Doctor Information

Check the box if your teen has reported, or you have observed, the following:

- ☐ Blurred vision at far
- ☐ Double vision
- ☐ Headaches
- ☐ Motion sickness/Car sickness
- ☐ Eyes frequently reddened
- ☐ Light sensitivity
- ☐ Head close to paper when reading or writing
- ☐ Avoids (dislikes) reading or near tasks
- ☐ Tilts head when reading
- ☐ Moves head when reading
- ☐ Skips, inserts, or rereads words
- ☐ Vocalizes when reading silently
- ☐ Poor reading comprehension
- ☐ Confuses letters or words
- ☐ Confuses right and left
- ☐ Writes neatly but slowly
- ☐ Difficulty copying from chalkboard
- ☐ Responds better orally than by writing
- ☐ Seems to know material, but does poor on test
- ☐ Poor general coordination
- ☐ Difficulty catching/hitting a ball
- ☐ Vision seems worse at the end of the day
- ☐ Writing uphill or downhill
- ☐ Misaligning digits in columns of numbers
- ☐ Holding reading material too close
- ☐ Difficulty with time management
- ☐ Difficulty with money concepts – making change
- ☐ Difficulty with scissors, calculator keys, etc.
- ☐ Misplaces or loses papers, objects, belongings …
- ☐ Tendency to knock things over on a desk or table
- ☐ Blurred vision at near
- ☐ Eyes hurt or tired
- ☐ Words moving on the page (run together)
- ☐ Dizziness/Nausea
- ☐ Excessive eye rubbing
- ☐ Frequent blinking
- ☐ Closing or covering one eye
- ☐ Prefers being read to
- ☐ Tilts head when writing
- ☐ Loses place while reading
- ☐ Uses finger as a marker
- ☐ Reads slowly
- ☐ Comprehension decreases over time
- ☐ Reverses letters or words
- ☐ Writes or prints poorly
- ☐ Tires easily
- ☐ Remembers better what is heard than seen
- ☐ Short attention span/loses interest
- ☐ Bumps into people/objects
- ☐ Avoids (dislikes) sports
- ☐ Burning, stinging, watery eyes
- ☐ Falls asleep when reading
- ☐ Omits small words when reading
- ☐ Inconsistent/poor sports performance
- ☐ Saying "I can't" before trying
- ☐ Inability to estimate distances accurately
- ☐ Difficulty with colors
- ☐ Forgetful, poor memory
- ☐ Moves lips while reading
- ☐ Difficulty completing assignments on time

LEISURE TIME ACTIVITIES/TELEVISION AND COMUTER VIEWING

Computer: Hours/day?____continuous or on/off Days/week?_____ Viewing Distance?_____
Video Games: Hours/day?____continuous or on/off Days/week?_____ Viewing Distance?_____
Television: Hours/day?____continuous or on/off Days/week?_____ Viewing Distance?_____
What programs does (s)he like the best?_____
What other activities occupy your teen's leisure time?_____
Are there any activities your teen would like to participate in, but doesn't? No☐ Yes☐
Please explain:_____

Patient Name: _____Date Form Completed: _____

DEVELOPMENTAL HISTORY

Was your child carried to a full term pregnancy? No□ Yes□
Did the mother experience any health problems during pregnancy? No□ Yes□
If yes, explain:_____
Normal birth? No□ Yes□
Any complications before, during, or immediately following delivery? No□ Yes□
If yes, explain:_____
Birth weight:_____ Apgar scores at birth:_____ After 10 minutes:_____
Were forceps used? No□ Yes□
Was there ever any reason for concern over your teen's general growth or development? No□ Yes□
If yes, why? _____
Was your teen an "easy" or "difficult" baby? _____ Good or fussy? _____
Any colic or early management problems? No□ Yes□
If yes, describe:_____
Did your child crawl (stomach on floor)? No No□ Yes□ At what age?_____
Did your child creep (on all fours)? No□ Yes□ At what age?_____
If not, describe:_____
At what age did this child pull upon chairs and tables? _____
At what age did this child walk? _____
Was your teen active, in the crib, as a baby? No□ Yes□ Is your teen still active? No□ Yes□
Speech: First words:_____ At what age? _____
Was early speech clear to others? No□ Yes□ Is speech clear now? No□ Yes□
Could your teen dress him/herself as a younger child? No□ Yes□
Button clothes as a child? No□ Yes□ Tie bows as a child? No□ Yes□
Zip zippers as a child? No□ Yes□ Lace shoes as a child? No□ Yes□
Could (s)he do these before entering school? No□ Yes□
Teen's dominant hand (circle): right or left Has guidance been given in use of hand? No□ Yes□
Has a speech/language evaluation been performed? No□ Yes□ By Whom?_____
Results and recommendations:_____
Is your teen adopted? No□ Yes□ If yes, year?_____ Does your teen know? No□ Yes□

SCHOOL

Name and Address of school:_____
Grade:___ Teacher:_____ School nurse:_____ Principal:_____
Age at time of entrance to: Pre-school:_____ Kindergarten:_____ First Grade:_____
Does your teen like school? No□ Yes□
Specifically describe any school difficulties: _____
_____
Has your teen changed schools often? No□ Yes□
If yes, when? _____
Has a grade been repeated? No□ Yes□
If yes, which and why? _____
Does your teen seem to be under tension or pressure when doing school work? No□ Yes□
Has your teen had any special tutoring, therapy, and/or remedial assistance? No□ Yes□
If yes, when?_____ How long? _____
Where and from whom? _____
Results:_____

Patient Name: _____Date Form Completed: _____

SCHOOL, Cont.

Does your teen like to read? No□ Yes□
Voluntarily? No□ Yes□
Does your teen read for pleasure? No□ Yes□
What type of material? _____
What is your teen's attitude toward reading, school, his/her teachers, other youngsters? _____
_____
Overall schoolwork is: above average □ average □ below average □
Which subjects are:
Above average:_____
Average:_____
Below average:_____
Does your teen need to spend a lot of time/effort to maintain this level of performance? No□ Yes□
How much time on average does your teen spend each day on homework assignments?_____
To what extent do you assist your teen with homework?_____
Do you feel your teen is achieving up to potential? No□ Yes□
Does the teacher feel your teen is achieving up to potential? No□ Yes□
Does your teen receive special services or accommodations from school? No□ Yes□
If yes, list services or accommodations:_____
Does your teen's school personnel consider your teen to have a learning problem? No□ Yes□
Does your teen's school personnel consider your teen to have a behavior problem? No□ Yes□

REVIEW OF SYSTEMS

In addition to our desire for a complete health history, the following review of systems is required for insurance reimbursement. Please circle all that apply to your teen – if none of the symptoms apply, check the box to the left (acknowledges you have reviewed the symptoms).

□ Constitutional: Excessive appetite or thirst, Fever today, Recent weight gain or loss
□ Cardiovascular: Chest pain, Irregular heart beat, Swelling of ankles or hands
□ Ears, Nose, Throat: Earaches or drainage, Hearing loss or injury, Nasal congestion, Ringing in ears, Sore mouth or throat, Vertigo
□ Endocrine: Diabetes, Pituitary disease, Thyroid disease (high or low)
□ Gastrointestinal: Abdominal pain, Blood in stool, Chronic diarrhea, Nausea, Reflux, Vomiting
□ Genitourinary: Blood in urine, Discharge, Pain with urination, Frequent bedwetting
□ Hematological/Lymphatic: Bleeding disorders, Slow healing, Swollen glands
□ Musculoskeletal: Difficulty with walking, Joint pain or stiffness, Muscle pain or cramps, Frequent "growing pains"
□ Neurological: Confusion, Dizziness, Numbness, Severe headache, Tingling, Tremors
□ Psychiatric: Anxiousness, Depressed, Unable to concentrate
□ Respiratory: Cough, Coughing up blood, Shortness of breath, Wheezing
□ Skin/Breast: Birthmarks that have changed color or size, Breast lump, Excessive dryness, Rashes

Patient Name: _____Date Form Completed: _____

MEDICAL HISTORY

Physician's name:_____ Date of last evaluation:_____
For what reason? _____
Results and recommendations:_____
_____
Teen's current state of health:_____
List current medications, including vitamins and supplements:_____
_____
For what condition(s)? _____
Any reactions to immunization(s)? No☐ Yes☐ If yes, explain:_____
_____
_____

List any illnesses, bad falls, high fevers, etc.:

Age	Description	Mild/Severe	Complications

Is your teen generally healthy? No☐ Yes☐ If no, explain:_____
_____
Are there any chronic problems like ear infections, asthma, hay fever, allergies? No☐ Yes☐
If yes, please list:_____
Has a neurological evaluation been performed? No☐ Yes☐ By whom? _____
Results and recommendations:_____
Has a psychological evaluation been performed? No☐ Yes☐ By whom? _____
Results and recommendations:_____
Has an occupational therapy evaluation been performed? No☐ Yes☐ By whom? _____
Results and recommendations:_____

Is there any history of the following? (Please check if it applies to the patient or a family member.)

	Patient	Relative/Parent/Sibling		Patient	Relative/Parent/Sibling
Diabetes	☐	☐Who?_____	Cataracts	☐	☐Who?_____
High Blood Pressure	☐	☐Who?_____	Glaucoma	☐	☐Who?_____
Thyroid Disease	☐	☐Who?_____	High Eye Pressure	☐	☐Who?_____
Retinal Disease	☐	☐Who?_____	Blindness	☐	☐Who?_____
Chromosomal Disease	☐	☐Who?_____	Amblyopia	☐	☐Who?_____
Learning Disability	☐	☐Who?_____	Cross or Wall eye	☐	☐Who?_____

Diagnosed/suspected Strabismus (eye turn)_____When:_____By Whom?_____
Diagnosed/suspected Amblyopia ("lazy eye")_____When:_____By Whom?_____
Diagnosed/suspected Dyslexia_____When:_____By Whom?_____
Diagnosed/suspected ADD/ADHD_____When:_____By Whom?_____
Diagnosed/suspected Food Allergies_____When:_____By Whom?_____
Diagnosed/suspected Chemical Sensitivities_____When:_____By Whom?_____
Diagnosed/suspected Head or Brain Trauma_____When:_____By Whom?_____
Diagnosed/suspected Autism Spectrum Disorder _____When:_____By Whom?_____
Diagnosed Special Needs Condition: Name:_____When:_____By Whom?_____