RAOPTOMETRISTS
Caboolture

PARENT PRE-EXAMINATION QUESTIONNAIRE

This form provides initial information for a visual examination. This goes beyond the traditional sight examination. It investigates how efficiently your child understands what he/she sees. Optimum school performance requires optimum visual function. If possible, it is helpful if both parents could attend the consultation.

Child's Full Name: ..... Date of Birth: .....
Teacher's Name: .....
School:..... Grade: .....
Who recommended that you consult us?.....
Are there are any Family Court Orders in place in relation to this child? Yes ☐ No ☐

A. Visual History

1. What is the reason for today's visual examination?
   .....
   .....
2. Previous visual examinations When ……. & by Whom.....
3. Were any glasses prescribed? Yes ☐ No ☐
4. If so, for what purpose? .....
5. Has your child seen any of the following Allied Health practitioners?

   Occupational Therpist ☐ Speech Therapist ☐ Chiropractor ☐ Paediatrician ☐

6. Diagnosis……..……
7. Medications……..

Please bring along any reports to the appointment that you think may be helpful or necessary.

B. Family Visual History

Relation to child	Visual Problem	At what age
.....		
.....		

Is there any history in your family of the following:

Diabetes Yes ☐ No ☐
Glaucoma Yes ☐ No ☐
Does/did anyone in the immediate family have a learning problem? Yes ☐ No ☐

PLEASE NOTE

1. Could you please bring any spectacles your child has worn to the consultation.
2. Please include any additional information and reports from other professionals that are helpful to our understanding of your child.

C. Signs and Symptoms - please put a tick in the column that most applies to the following symptoms.

	Never	Seldom	Occasionally	Frequently	Always
Headaches with near work					
Words run together when reading					
Burning, itchy or watery eyes					
Skips or repeats lines with reading					
Head tilt or closes one eye with reading					
Difficulty copying from the whiteboard					
Avoids near work or reading					
Omits small words reading					
Writes up or down hill					
Misaligns digits or columns of numbers					
Holds reading too close					
Reading comprehension down					
Trouble keeping attention on reading					
Difficulty completing written work on time					
Always says "I can't" before trying					
Clumsy, knocks things over					
Does not use time well					
Loses belongings					
Forgetful, poor memory					

D. School History

1. Have there been any academic difficulties? Yes ☐ No ☐
   Please explain .....
2. What are your child's strengths? .....
3. Has your child had any learning support?.....
   .....
4. What sports does your child play?.....
5. Does your child play a musical instrument?.....

E. Developmental/Health History

1. Were there any complications during pregnancy or birth?.....
2. Is your child generally healthy?.....
3. Any allergies, hay fever, asthma?.....
4. Medication at present?.....
5. Who is your child's doctor?.....
6. List any injuries to the eyes or head.....
7. Did your child crawl on all fours? Yes ☐ No ☐ Age walked.....
8. Was early speech clear to others? Yes ☐ No ☐
9. Approximately what age did your child know their colours? .....
10. Is there any indication of a hearing problem? Yes ☐ No ☐
11. Has your child suffered from recurrent ear infections? Yes ☐ No ☐
12. Does or has your child experienced poor sleep patterns? Yes ☐ No ☐