**Lambert Fick**
**BEHAVIOURAL OPTOMETRISTS**
LAMBERTFICK.CO.ZA

# QUESTIONNAIRE YOUNG CHILD

| | |
|---|---|
| Child's full name: | Date of Birth: |
| Child's Nick name: | Referred by: |
| | |
| **FAMILY INFORMATION:** | |
| Father's Name: | Mother's Name: |
| Home Address: | Postal Code: |
| Home Telephone: | Occupation: |
| Employer: | Work Telephone: |
| Business Address: | Postal Code: |
| Spouse Occupation: | Work Telephone: |
| Business Address: | Postal Code: |
| Medical Aid: | Option: |
| Policy Number: | |

## VISUAL HISTORY:

Previous Examination: Dr's Name:..... Date:.....

Results: .....

.....

Was treatment recommended ? Y N

| Type of treatment recommended (Tick where appropriate) | | | | |
|---|---|---|---|---|
| Vision Therapy | Patching | Glasses | Surgery | Other |

| Members of family who have had visual attention and why: | | |
|---|---|---|
| NAME | AGE | VISUAL SITUATION |
| | | |
| | | |
| | | |

Please check the following observations and/or complaints as they relate to your child

| | Never | Seldom | Occasionally | Frequently | Always |
|---|---|---|---|---|---|
| Eyes turn in | | | | | |
| Eyes turn out | | | | | |
| Squinting | | | | | |
| Rubs eyes | | | | | |
| Doesn't see things | | | | | |
| Eyelids droop | | | | | |
| Turns the head to use one eye only | | | | | |
| Covers or closes one eye | | | | | |
| Blinks excessively | | | | | |
| Places an object close to eyes to look at it | | | | | |
| Stares at bright lights | | | | | |
| Thrusts head forward or backward while looking at distance/near objects | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Stumbles over objects | | | | | |
| Transfer objects from hand to hand, crossing the middle of his/her body | | | | | |
| Reddened eyes or eyelids | | | | | |
| Frequent sties | | | | | |
| Eyes in constant motion | | | | | |
| Has watery eyes | | | | | |
| Turns the head to one side | | | | | |
| Abnormally bothered by bright light | | | | | |
| Avoids looking at/playing with close objects | | | | | |
| Unable to see distance objects | | | | | |
| Complains of burning, itching, painful eyes | | | | | |

## MEDICAL HISTORY:

Most recent medical examination: Dr's Name: ..... Date: .....
Results:

.....

Medications currently using / for what condition?

.....

.....

Did the mother experience any health problems during the pregnancy, especially during the first trimester? Yes ☐ No ☐

If Yes , Please explain:

.....

.....

Did the mother take any medications during the pregnancy? Yes ☐ No ☐

If yes, name the medication and number of months pregnant at time.

.....

.....

Is your child healthy? Yes ☐ No ☐

List illnesses, bad falls, high fevers, etc.

| Age | Illness | Severity | Complications |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are there any chronic problems like asthma, sinusitis allergies (food or other), ear infections?
Yes ☐ No ☐

If yes, please list: .....

.....

.....

Immunizations received and at what age? Yes ☐ No ☐ If Yes please list:

| Immunization: | Age: | Complications |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Has a neurological evaluation been performed? Yes ☐ No ☐ Dr's name .....

Results: .....

Any history in your families of the following? (Please check and give relationship to child)

| Name of Illness | Y | N | Relationship,eg mother, father |
|---|---|---|---|
| Diabetes | | | |
| High Blood Pressure | | | |
| Multiple Sclerosis | | | |
| Thyroid condition | | | |
| Chromosomal disease | | | |
| Glaucoma | | | |
| Cataracts | | | |
| Crossed/Walled eyes | | | |
| Amblyopia (lazy eye) | | | |
| Near sighted | | | |
| Far sighted | | | |
| Astigmatism | | | |
| Turned eye | | | |
| Blindness | | | |
| If other, please explain | | | |

.....

## DEVELOPMENTAL HISTORY:

Mother's age when child was born:_____

Birth Weight_____ Full term pregnancy: ☐ Yes ☐ No

Labour lasted for_____ hours

Labour was induced: Yes ☐ No ☐

Delivery was: Natural ☐ Caesarean ☐ Anaesthetic ☐ Forceps ☐

Any complications before, during or immediately following delivery? Yes ☐ No ☐

Please Explain: .....

.....

Any Oxygen given Yes ☐ No ☐ If yes, what concentration _____

Amount of times on oxygen_____ Reason .....

Incubator: Yes ☐ No ☐ If yes, how long_____

Was there any reason for concern for your child's general growth or development?

Yes ☐ No ☐

If yes, why .....

.....

| Where appropriate, please list our child's age when he/she could do the following: | | | |
|---|---|---|---|
| Responsive smile | | Walked alone | |
| Laughs | | Scribbles spontaneously | |
| Rolled over | | Imitates housework | |
| Reaches for objects | | Walks Backwards | |
| Crawl (stomach on floor) | | Uses spoon/little spilling | |
| Creep (stomach off floor) | | Walks up stairs | |
| Responded to words or names | | Used two word sentences | |
| Gave first name | | Become toilet trained | |

What percentage of the waking hours is your child in a playpen_____ walker ____

seat _____"jumping jack"____

What can your child do very well? .....

.....

What things are difficult for your child? .....

.....

Name of Day Care Centre (if appropriate) .....

Address ..... Postal Code .....

## NUTRITIONAL INFORMATION:

Breast feeding: Never ☐ Y ☐ N Currently ☐ Y ☐ N Breast feeding until .....

Started with Solid food at what age: ..... What type of solid food .....

Activity Level: HIGH ..... MODERATE ..... LOW .....

Are there periods of very high energy? ☐ Y ☐ N

Are there periods of very low energy? ☐ Y ☐ N

## BEHAVIOUR:

Do you have any concerns about your child's behaviour? Yes ☐ No ☐

If Yes, what are they:

.....

.....

PLEASE check the appropriate spaces if you have any concerns about the following behaviour(s) in your child:

| | | | | | |
|---|---|---|---|---|---|
| Lack of curiosity | | Irritable, easily upset | | Thumb sucking | |
| Restlessness/sleeplessn | | Nervous | | Glum, sulky, moody | |
| Bad temper | | Has difficulty separating from parents | | | |

## PERSONALITY:

PLEASE describe your child's personality: