Larkspur Landing Optometry **Dr. Gina Day**

Pediatric Vision Questionaire

Date_____

Child's name _____ Birthday ___/___/___
Mother's name _____ Father's name_____
Address _____ City/Zip _____
Home phone _____ Work phone _____ mom or dad?
School _____ Teacher _____ Grade _____
Referred to this office by_____

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

Has the teacher/school expressed concern about possible vision difficulty?_____

Date of last vision exam _____ Doctor's name _____
Reason for last examination_____
Were glasses prescribed? _____ Are they worn? _____ When? _____
Is there any history of vision difficulty in the family? _____

	Yes	No
School performance up to potential		
Attending grade level expected for age		
Frowns or squints to see something		
Complains of print "running together" or "jumping around"		
Experiences unusual fatigue or headaches after reading/studying		
One eye turns in or out		
Red eyes or eyelids		
Eyes water or rubs eyes frequently		
Closes or covers one eye in bright light or during visual tasks		
Skips and rereads words and/or letters		
Uses finger as marker when reading		
Avoids close work		
Holds books too closely		
Reversals when reading (was-saw, on-no) or writing (b for d, p for q)		
Poor recall of visually presented materials		
Transposition of letters or numbers (21 for 12)		
Makes errors in copying from blackboard to paper		
Poor handwriting		
Clumsiness		

Where would you like copies of your child's vision report sent?
(please provide addresses as needed)
☐ home ☐ teacher ☐ referring specialist ☐ pediatrician