the eyesite **Pediatrics/Binocular Service Questionnaire** (989) 773-2020

Patient's Name:________________________ Today's Date:________________

Sex: ☐ M ☐ F Date of Birth:________________ Pediatrician:________________

School:________________ Grade:________ Hobbies: Sports Reading Computers Other:____________

Parent's Names:________________________ Siblings:________________________

Reason for Visit:____

Patient's Ocular History: Date of Last Eye Exam:________________ By whom:________________

Does the patient wear glasses? ☐ Y ☐ N If yes, what are they used for? ☐ Distance ☐ Near ☐ Other

Does the patient wear contact lenses? ☐ Y ☐ N Has the patient had vision therapy? ☐ Y ☐ N

Has the patient had an eye patched? ☐ Y ☐ N Has the patient had eye surgery? ☐ Y ☐ N

Has the patient had any eye injuries? ☐ Y ☐ N Has the patient had any eye infections? ☐ Y ☐ N

Please check any of the following that apply to the patient: ☐ **No problems observed or reported**

☐ Blurry vision
☐ Double vision
☐ Eye pain
☐ Burning
☐ Itching
☐ Tearing, watering
☐ Floaters
☐ Squinting
☐ Rubs eyes
☐ Dry eyes
☐ Eye strain/fatigue
☐ Lazy/wandering eye
☐ Flashes of light
☐ Light sensitivity
☐ Difficulty tracking an object
☐ Drooping of eyelid
☐ Frequent blinking
☐ Redness around eyes
☐ Covers or closes an eye
☐ Discharge from eyes

Family Ocular History – Please check any of the following that apply to family members:

☐ Wears glasses
☐ Lazy eye
☐ Glaucoma
☐ Macular Degeneration
☐ Wandering eye
☐ Blindness
☐ Other:________________

Patient's Medical History: **Date of last medical exam:**________________ **By whom:**________________

Please check any of the following that apply to the patient: ☐ **No problems observed or reported**

☐ Diabetes
☐ Allergies
☐ Asthma
☐ Behavioral problems
☐ Attention Deficit Disorder
☐ High blood pressure
☐ Heart disease
☐ Other cardiovascular problems
☐ Neurological disease
☐ Mental health problems
☐ Hearing or ear problems
☐ Skin problems
☐ Other endocrine problems
☐ Musculoskeletal problems
☐ Gastrointestinal problems
☐ Genitourinary problems
☐ Other:________________

List any medications the patient is currently taking: **List any known drug allergies:**

Is the patient currently receiving any of the following services? (Check all that apply)

☐ Special Ed ☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy ☐ Tutoring ☐ Other:________________

Check any of the following that you have observed in the patient: ☐ **No problems observed or reported**

☐ Trouble finishing work
☐ Impulsive
☐ Frustrates easily
☐ Lacks confidence
☐ Difficulty sitting still
☐ Difficulty paying attention
☐ Complains of headaches
☐ Complains of blurry vision
☐ Complains of eye pain or fatigue
☐ Avoids reading or writing
☐ Loses place while reading
☐ Skips or rereads words or letters
☐ Reads below grade level
☐ Poor reading comprehension
☐ Poor handwriting
☐ Poor spelling skills
☐ Complains of letters moving around
☐ Reverses letter when reading or writing
☐ Uses finger to keep place when reading
☐ Fails to complete work on time

Has the patient received any special testing associated with school performance? ☐ Y ☐ N If yes, please explain:

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Has the patient had an individualized education plan (IEP) with the school? ☐ Y ☐ N

Do (or did) any other members of the family have problems in school? ☐ Y ☐ N If yes, indicate who and describe briefly the problems they experienced:________________________________

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