optometry@cooroy
guidance to enhance, transform & preserve your vision

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PARENT PRE-EXAMINATION QUESTIONNAIRE

By filling out this form you will be giving us information to best assess your child's vision.

Your child's visual examination will be more that just a traditional eyesight test. As well as eyesight & eye health, we investigate how efficiently your child's eyes team together, how your child takes in information & how well they understand what they see. We believe optimal school performance requires the development of optimal visual skills

Child's Name ..... (First) ..... (Last) Date of birth .....

Preferred name ..... Name of person filling out this form (inc. title) .....

MEDICARE NUMBER ..... Reference ..... Expiry .....

Street Address ..... Postal Address (if different) .....

....

..... Postcode .... Postcode .....

☐ Phone ..... ☐ Mobile ..... ☐ Work (parent/guardian) .....

☐ Email ..... (*Please tick your preferred first method of contact)*

BILLING INFORMATION

CHILDREN UNDER 5 YEARS: Initial consultation direct-billed to Medicare (ONLY if eligible for maximum rebate); allow 30-45 min.

PRIMARY SCHOOL, YOUNGER HIGH SCHOOL, or HIGH SCHOOL CHILDREN WITH LEARNING OR COMPLEX ISSUES:

Initial comprehensive consultation **$145.00*** (up to $62.15 rebate claimable through Medicare); allow 60 min.

This fee covers the costs for providing more than just a basic vision test. We offer a comprehensive visual examination including a screening of important visual perceptual & processing skills that can impact on your child's learning, retinal imaging might be included

SECONDARY SCHOOL CHILDREN (without learning issues):

Initial comprehensive consultation **$95.00*** (up to $62.15 rebate claimable through Medicare): allow 45 min.

** a 15% discount on consultation items applies only to **PENSION** Concession Card Holders*

1. Does your child have any of the following entitlements? ☐ Yes ☐ No
   ☐ Pensioner ☐ Health Care Card ☐ Veterans Affairs

If yes, card number including expiry date .....

2. Do you have extras cover with a private Health Insurance Fund? ☐ Yes ☐ No

If yes, Fund Name..... Card no..... Ref.....

VISUAL HISTORY

1. Briefly, what is the reason for today's visual examination? .....
   .....
2. Has your child had any previous visual examinations? ☐ Yes ☐ No
   a. If yes, when? ..... By whom? .....
3. Has your child been prescribed glasses previously? ☐ Yes ☐ No
   a. If yes, when were they to be worn? ☐ constant ☐ for reading only ☐ in class ☐ for distance
   b. If yes, does your child still use their glasses? ☐ Yes ☐ No
4. Has your child had any other form of visual treatment, such as eye exercises or patching? Yes ☐ No ☐
   If yes, please explain .....

SIGNS AND SYMPTOMS

Have you or anyone else noted the following about your child? *(Please tick all that apply)*

- ☐ Headaches regularly
- ☐ Head extremely tilted while doing close tasks
- ☐ Poor attention span on close visual tasks
- ☐ Poor eye/hand co-ordination
- ☐ Frequent blinking or ☐ rubbing eyes
- ☐ One eye turning in, or ☐ one eye turning out
- ☐ Holds reading close
- ☐ Watery Eyes
- ☐ Red eyes
- ☐ Squinting
- ☐ Sits close to TV
- ☐ Itchy eyes
- ☐ Closes one eye, or ☐ covers one eye
- ☐ Glare sensitivity

Continued on the next page....

FAMILY VISUAL HISTORY

Is there a family history of any of the following?

☐ Strabismus (eye turn) ☐ Glaucoma ☐ Amblyopia (lazy eye)

☐ Macular Degeneration ☐ Learning problems or dyslexia ☐ Retinal Detachment

Details of above or other issues ……

……

……

SCHOOL HISTORY

1. School ..... Grade …….. Teacher's Name ……..

2. Has your child ever repeated a grade? ☐ Yes ☐ No If yes, what grade? ……

3. Have there been any academic difficulties?.....

4. Has your child had any learning support? ☐ Yes ☐ No If yes, in what form (eg: Special Ed, Tutoring)

……..

5. What are your child's strengths? .....

6. What does your child find most difficult? .....

7. Is your child active in sports activities? .....

DEVELOPMENTAL/HEALTH HISTORY

1. Who is your child's doctor and at what clinic? .....

2. 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. Has your child suffered any Injuries to the eyes or head or concussion? .....

7. Did your child crawl on all fours? ☐ Yes ☐ No Approx. age crawled ..... walked.....

8. Was early speech clear to others? ☐ Yes ☐ No

9. Is there any indication of a hearing problem? ☐ Yes ☐ No

10. Has your child suffered from recurrent ear infections? ☐ Yes ☐ No

11. Any other notes you feel are important to understanding your child ……..

……

……

……

Were you recommended to our practice by: family? ☐ friend? ☐ teacher? ☐ other professional? ☐

If yes, whom may we thank for recommending us? ……

Your Signature..... **Date**.....

PLEASE!/

1. *Bring with you to the appointment any spectacles your child has worn.*
2. *Include any additional information and reports from other professionals that would be helpful to our understanding of your child. These can be scanned and kept with your child's electronic file. All information will, of course, remain confidential.*
3. *In order to avoid distractions for your child, yourself and the optometrist during the examination,* ***It would also be appreciated if you could avoid bringing to the appointment siblings or other children*** *who cannot be left alone in the waiting room.*

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