

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 than 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 Date of birth

First Last

Preferred name Name of person filling out this form

Street Address Postal Address (if different)

.....

..... Postcode Postcode

Phone Mobile Work (parent/guardian)

Email (Please tick your preferred first method of contact)

CHILDREN UNDER 5 YEARS: Initial consultation direct-billed to Medicare (only if eligible for full rebate).

PRIMARY SCHOOL CHILDREN: Initial comprehensive consultation \$105.00* (up to \$57.70 rebatable through Medicare).
This fee covers the costs for providing more than just a basic vision test. We offer a comprehensive visual examination including including a screening of important visual perceptual & processing skills that can impact on your child's learning. Expect this visit to take up to 1 hour.

SECONDARY SCHOOL CHILDREN: Initial comprehensive consultation \$81.00* (up to \$57.70 rebatable through Medicare).
** a 15% discount on consultation items applies to only Pension Concession Card Holders*

- In most cases Medicare will pay full rebate on only one full eye test per patient (under 65 yrs) each 36 months.
Has your child had a full eye test elsewhere with another optometrist within the last 36 months?
Yes No Not sure
- Does your child have any of the following entitlements? Yes No
Pensioner Health Care Card Veterans Affairs
- Do you have cover with a private Health Insurance Fund? Yes No Fund Name
- Were you recommended to our practice by: family? friend? teacher? other professional?
If yes, whom may we thank for recommending us?

VISUAL HISTORY

- Briefly, what is the reason for today's visual examination?
- Has your child had any previous visual examinations? Yes No
a. If yes, when? By whom?
- 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
- Has your child had any other form of visual treatment, such as eye exercises or patching? Yes No
a. If yes, please explain

SIGNS AND SYMPTOMS

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

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

Continued on the next page....

SCHOOL HISTORY

School Grade Teacher's Name

1. What was their age at entering Preschool? Starting 1st Grade?
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?
8. Does your child play a musical instrument?

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

FAMILY VISUAL HISTORY

Relation to child (e.g. mother)	Visual Problem (if known, e.g. short-sighted)	At what age detected?
---------------------------------	---	-----------------------

1. Is there any history in your family of the following?
 - a. Diabetes? Yes No
 - b. Glaucoma? Yes No
2. Does/did anyone in the immediate family have a learning problem? Yes No

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 be appreciated if you could avoid bringing to the appointment siblings or other children** who cannot be left alone in the waiting room.

optometryatcooroy.com.au

62 Maple St, Cooroy 4563 info@optometryatcooroy.com.au
Tel: 07 5442 5555 Fax: 07 5442 5740