Bernstein Center *for* Visual Performance

Student History Questionnaire

Dear Parents/Guardian: Today's Date:________________

Your child's visual development is critical to the development of other functions such as walking, talking and motor planning. This process can be affected by illness during critical phases of development and/or familial history (genetics). Therefore, your thorough answers to these questions will help the doctor in determining how your child's vision has developed and allow for the most productive use of your time in the office.

Patient Information:

Last Name:________________ First:________________ MI:_____ D.O.B:________________

Street Address:________________

City:________________ State: _____ Zip: ________ Home Phone: ________________

Grade: __________ Name of School: ________________

Mother's Name: ________________ Father's Name: ________________

Mother's Cell Phone:________________ Father's Cell Phone:________________

Mother's Work Phone:________________ Father's Work Phone:________________

Mother's Email: ________________ Father's Email: ________________

List patient's siblings, with ages, if any: ________________

Please indicate preferred contacts: Pref Phone: ________________ Pref Email: ________________

How did you learn about us? (please circle) Another Patient / Doctor / PT / OT / School / Internet / Other

Name of Referring Professional / Patient / Website: ________________

Eye Health History:

Date of last eye exam: ________________ Name of Doctor: ________________

History of eye surgeries? Y / N When? __________ Explain: ________________

History of eye injuries? Y / N When? __________ Explain: ________________

Does the patient use any eye drops? Y / N What brand?________________

Does the patient wear glasses? Y / N Circle all that apply: full time – reading – computer – TV – distance - school

Describe any problems the patient has with his/her glasses: ________________

Does the patient wear contact lenses? Y / N Type: ________________

Describe any problems the patient has with his/her contacts: ________________

Has the patient ever done Vision Therapy? Y / N When? __________ Provider: ________________

Has the patient or a family member been diagnosed with any of the following:

Amblyopia / Lazy Eye ❍patient ❍family member Explain: ________________

Strabismus / Eye Turn ❍patient ❍family member Explain: ________________

Convergence Issues ❍patient ❍family member Explain: ________________

Tracking Issues ❍patient ❍family member Explain: ________________

Eye Focusing Issues ❍patient ❍family member Explain: ________________

Eye health continued…

Macular Degeneration	❍patient	❍family member	Explain: ______
Glaucoma	❍patient	❍family member	Explain: ______
Nearsightedness	❍patient	❍family member	Explain: ______
Farsightedness	❍patient	❍family member	Explain: ______
Astigmatism	❍patient	❍family member	Explain: ______
Blindness	❍patient	❍family member	Explain: ______
Other Eye Condition	❍patient	❍family member	Explain: ______

USING A SCALE OF 0 FOR NEVER, 1 FOR OCCASIONALLY AND 2 FOR FREQUENTLY, PLEASE INDICATE HOW OFTEN THE PATIENT EXPERIENCES OR REPORTS THE FOLLOWING SYMPTOMS:			
Skips words / lines reading		Confuses right and left	
Loses place reading		Difficulty tracking moving objects	
Substitutes words reading		Clumsiness, poor coordination	
Rereads words or lines		Poor hand-eye coordination	
Reverses letters, numbers or words		Poor sports performance	
Uses finger or marker to keep place		Sees more clearly with one eye than other	
Reads very slowly		Falls asleep while reading	
Poor reading comprehension		Difficulty with visual memory or sequencing	
Difficulty remembering what's been read		Difficulty with visual-spatial concepts	
Holds reading material very close (within 7-8")		Deficits in visual processing speed	
Squints, closes or covers one eye while reading		Frustration / anxiety with homework or schoolwork	
Head tilt / unusual posture while reading / writing		Academic decline as demands increase	
Headaches following reading or computer work		Verbal and knowledgeable but tests poorly	
Eyes hurt or feel tired following a visual task		Struggles with tasks requiring sustained attention	
Unusual fatigue following a visual task		Avoids near tasks such as reading	
Double vision		Restless, fidgety when focus is required	
Distance blurs when looks up from near work		Loses awareness of surroundings when focused	
Print jumps or runs together when reading		Must "feel" things to see them	
Print moves around or goes in and out of focus		Light sensitivity	
Skips words / lines copying		Car sickness / motion sickness	
Loses place copying		Unusual / frequent blinking	
Substitutes words copying		Unusual / frequent eye rubbing	
Poor spelling skills		Dry eyes	
Writing is crooked or poorly spaced		Red eyes	
Misaligns letters or numbers		Watery eyes	

PREGNANCY/BIRTH:

Duration of pregnancy: ❍Full-term ❍Premature: ______________ ❍Adopted, age ______ ❍Birth history unknown

Were there any complications during pregnancy (Anemia, Toxemia, Bleeding, Illness, Etc.)? Explain: ______________

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List any medications used during pregnancy: ____

❍Natural birth ❍C-section ❍Fertility treatments used ❍Multiple births ❍Induced ❍Forceps/Suction used

Birth weight: _____________ Apgar scores: ___/____ Extended hospital stay? Y / N Duration: __________________

Were there any complications during or shortly after delivery? Y / N Explain: ________________________________

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DEVELOPMENTAL HISTORY:

At what age did the patient reach the following milestones? (Please indicate any significant delays)

Sit without support: ______________________________ Speak in sentences: ______________________________

Crawl: ______________________________ Toilet train: ______________________________

Walk: ______________________________ Tie Shoelaces: ______________________________

Talk (two or more words): ______________________________ Ride a bike (no training wheels): ______________________

Was crawling uncoordinated (backwards, stomach on floor, etc.)? ____

Is/was walking or running uncoordinated? ____

Does the patient have sensory sensitivities such as touch, sounds, picky eating, etc.? __________________________

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Does/did the patient receive early intervention services? Y/N ____

How many hours a day does patient spend on: TV: __________ Computer: __________ Phone or tablet: __________

What types of indoor activities does the patient enjoy? (drawing/coloring/puzzles/legos/dolls/etc.)

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What types of outdoor activities does the patient enjoy? ____

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Does the patient participate in organized/competitive athletic activities? _______________________________________

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Describe the patient's social interactions/friendships/family relationships (shy/makes friends easily/controls play often teased/friends same age or prefers older or younger peers/etc.) ______________________________________

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MEDICAL HEALTH HISTORY:

Date of last physical exam: ________________ Name of Doctor: ____

Address: ____ Phone: ______________________________

List any medications, vitamins or supplements the patient is currently taking: ________________________________

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Is the patient allergic to any medication? ____

Does the patient suffer from other allergies? ____

Did the patient have frequent ear infections? Y / N Were tubes put in? Y / N When? _________________________

Surgeries or Hospitalizations: ____

Has the patient or a family member been treated for conditions related to:

Ears/Nose/Throat	❍patient	❍family	Explain: ______________________________
Cardiovascular Disease	❍patient	❍family	Explain: ______________________________
Respiratory Disease	❍patient	❍family	Explain: ______________________________
Autoimmune Disease	❍patient	❍family	Explain: ______________________________
Cancer/Endocrine	❍patient	❍family	Explain: ______________________________
Other Systemic Disease	❍patient	❍family	Explain: ______________________________
Neurological Disorder	❍patient	❍family	Explain: ______________________________
Psychiatric Disorder	❍patient	❍family	Explain: ______________________________
Other	❍patient	❍family	Explain: ______________________________

Has the patient ever undergone any of the following testing/treatment:

Neurological	Date: ________	Provider: ______________________________	Report available? Y / N
Psychological	Date: ________	Provider: ______________________________	Report available? Y / N
Educational	Date: ________	Provider: ______________________________	Report available? Y / N
Audiological	Date: ________	Provider: ______________________________	Report available? Y / N
Physical Therapy	Date: ________	Provider: ______________________________	Report available? Y / N
Occupational Therapy	Date: ________	Provider: ______________________________	Report available? Y / N
Speech Therapy	Date: ________	Provider: ______________________________	Report available? Y / N
Other	Date: ________	Provider: ______________________________	Report available? Y / N

Additional medical information:

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EDUCATIONAL HISTORY:

Does the patient generally enjoy school? Y / N   Has the patient: ❍Skipped a grade____ ❍Repeated a grade____

Is the patient on grade level for reading? Y / N Explain: ____________________

Is the patient on grade level for math? Y / N Explain: ____________________

Is the patient in any special classes? Y / N Explain: ____________________

Does the patient have a 504 or IEP? Y / N Explain: ____________________

Does the patient receive any of the following (please indicate whether through school or privately):

❍Tutoring/academic support in: ____________________ Times/week: ________ ❍School ❍Private

❍Occupational Therapy Times/week: ________ ❍School ❍Private

❍Physical Therapy Times/week: ________ ❍School ❍Private

❍Speech Therapy Times/week: ________ ❍School ❍Private

❍Other: ____________________

List any subjects that seem particularly easy: ____________________

List any subjects that seem particularly difficult:____________________

Explain any specific concerns (yours and/or teachers) with how the patient is progressing in school: ______________

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Please use this space to provide any additional information you'd like to share with the doctor:

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By signing below, I certify that I understand I am financially responsible for all fees whether or not payable by insurance. I hereby authorize The Bernstein Center for Visual Performance to release all information necessary to secure the payment of benefits.

Responsible Party Signature (over 18 years):____________________

Relationship (if someone other than patient signing this form): ____________________Date:______________