RBE Children's Vision Center

41 East Front Street, Red Bank, NJ 07701
Phone: 732-741-0170 • Fax: 732-741-2808
redbankkidseyes.com

Patient Questionnaire for Patients 5–18 *Please print clearly*

Today's Date _____

GENERAL INFORMATION

Patient's Name (First) _____ (Last) _____

Name they prefer _____ Date of Birth _____ Gender ❑ Male ❑ Female

Address _____ City _____ State _____ Zip _____

Language preference ❑ English ❑ Spanish ❑ Other: _____ Ethnicity *(Italian, Polish, etc.)* _____

Race ❑ Caucasian ❑ African American ❑ Hispanic ❑ Asian ❑ Middle-Eastern ❑ Pacific Islander ❑ Native American

Parents/Guardians

Parent's/Guardian's Names _____

Parent's Phone# _____ Whose number? ❑ Mom ❑ Dad ❑ Other_____

Parent's Email _____ Contact Preference *(email, cell, text etc.)* _____

Parent's Phone# _____ Whose number? ❑ Mom ❑ Dad ❑ Other_____

Parent's Email _____ Contact Preference *(email, cell, text etc.)* _____

Person who holds primary health *(or vision)* insurance:

Name _____ Date of Birth _____

Insurance Carrier _____ ID Number _____

Social Security # _____

Person who holds secondary health *(or vision)* insurance:

Name _____ Date of Birth _____

Insurance Carrier _____ ID Number _____

Social Security # _____

Pediatrician Info : Do you have a pediatrician? ❑ Yes ❑ No

Doctor's name _____ Office Address _____

Phone # _____ Fax # _____

May we update your pediatrician? ❑ Yes ❑ No

Were you referred to our office? ❑ Yes ❑ No By Whom? _____

PRESENT SITUATION

Has your school or another professional expressed concern about your child's vision? ❑ Yes ❑ No

If yes, what concerns? _____

_____

Any other complaints or concerns your child makes about his/her vision? _____

_____

VISUAL HISTORY

Has your child been previously evaluated by an eye care professional? ❑ Yes ❑ No

If yes, Doctor's Name _____ Date of last evaluation _____

Reason for examination _____

Results & recommendations _____

Does your child wear glasses/contacts or use a special optical device? ❑ Yes ❑ No

If yes, what? _____

Are they used? ❑ Yes ❑ No *If yes,* when? _____

If not used, why not? _____

Has your child had eye surgery? ❑ Yes ❑ No

Has your child had an eye injury or infection? ❑ Yes ❑ No

By whom _____ For what _____

MEDICAL HISTORY

Height _____ Weight _____

Medication	Date started	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check any of the following applying to your child:

❑ History of chronic ear infections
❑ Tubes in ears
❑ Been diagnosed on the autism spectrum
❑ Allergies
Please specify _____
❑ Brain injury/concussion
Please specify _____
❑ Uses a mobility aid
Please specify _____

❑ Had neurological evaluation
By whom _____
Results _____
_____
❑ Had occupational/speech/physical therapy/ psychological evaluation
By whom _____
Results _____
_____

HAS THE PATIENT EVER HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING CONDITIONS?

Constitutional Symptoms
❑ Fever
❑ Weight Loss
❑ Fatigue

Ears/Nose/Mouth
❑ Poor Hearing
❑ Hearing Aid
❑ Sinus Problems

Cardiovascular
❑ High Blood Pressure
❑ Poor Circulation
❑ Heart Flutter
❑ Pacemaker
❑ Edema (Swelling)

Respiratory
❑ Shortness of Breath
❑ Asthma
❑ Tuberculosis
❑ Cystic Fibrosis

Gastrointestinal
❑ Upset Stomach
❑ Ulcer(s)
❑ Esophageal Reflux
❑ Gastritis
❑ Ulcerative Colitis
❑ Diarrhea

Genitourinary
❑ Painful Urination
❑ Frequency of Urination

Musculoskeletal
❑ Arthritis
❑ Muscular Disorder

Skin
❑ Rash
❑ Eczema
❑ Hair Loss
❑ Dry/Itchy Skin or Scalp
❑ Rosacea

Neurological
❑ Seizure Disorder
❑ Fainting Spells
❑ Stroke

Psychiatric
❑ Mental Health Concerns

(continued)

Endocrine

- ❑ Thyroid
- ❑ Diabetes Type I
- ❑ Diabetes II
- ❑ Excessive Weight Gain/Loss
- ❑ Excessive Thirst or Urination
- ❑ Get up frequently at night to urinate

Hematology/Lymphatic

- ❑ Blood Disorder
- ❑ Excessive Bleeding
- ❑ Blood Clotting Problem
- ❑ Bruise Easily

Allergy/ Immunology

- ❑ Seasonal Allergies
- ❑ Other Allergies
- ❑ Autoimmune Disease
- ❑ Sarcoidosis
- ❑ Lupus
- ❑ Scleroderma
- ❑ Juvenile Rheumatoid Arthritis
- ❑ Shingles

FAMILY MEDICAL HISTORY

❑ Cataracts ❑ Glaucoma ❑ Macular Degeneration ❑ Diabetes ❑ Heart Disease ❑ Seizure ❑ Eye Turn

❑ Retinal Detachment ❑ High Blood Pressure ❑ Other _____

DEVELOPMENTAL HISTORY

How many weeks was the pregnancy? (Number of weeks) _____

Did the mother experience any health problems during pregnancy? ❑ Yes ❑ No

If yes, explain _____

❑ Natural birth ❑ C-section Were forceps used? ❑ Yes ❑ No Was the child on oxygen at any point after birth? ❑ Yes ❑ No

Birth Height _____ Birth Weight _____

Were there any complications before, during, or immediately after delivery? ❑ Yes ❑ No

If yes, explain _____

Was there ever any concern for your child's general growth or development? ❑ Yes ❑ No

If yes, explain _____

APGAR score _____

At what age did your child sit? _____ crawl?_____

At what age did your child walk? _____ talk? _____

Dominant hand ❑ Right ❑ Left ❑ Undetermined

How are their fine motor skills? ❑ Above Average ❑ Average ❑ Below Average

Did your child frequently walk on their toes? ❑ Yes ❑ No

Is your child's speech clear to others? ❑ Yes ❑ No

LEISURE ACTIVITIES

	How often?	Viewing distance?
❑ Watch TV?	_____	_____
❑ Play video games?	_____	_____
	How often?	**Average length of sessions**
❑ Use small screen devices?	_____	_____

Other leisure activities _____

Other leisure activities you'd like your child to participate in, but currently doesn't _____

Please explain _____

SCHOOL HISTORY

Name & Address of School _____

_____

Grade _____ Teacher: _____

Does your child like school? ❑ Yes ❑ No Age at entrance to pre-school_____

Describe any difficulties _____

Favorite Subject _____

Least Favorite Subject _____

Performance in science? ❑ Above Grade Level ❑ At Grade Level ❑ Below Grade Level

Performance in math? ❑ Above Grade Level ❑ At Grade Level ❑ Below Grade Level

Performance in reading? ❑ Above Grade Level ❑ At Grade Level ❑ Below Grade Level

Do you feel your child is developing/achieving to his/her potential? ❑ Yes ❑ No

Does their teacher feel your child is developing/achieving to his/her potential? ❑ Yes ❑ No

Has the child ever repeated a grade? ❑ Yes ❑ No If so, what grade? _____

Does the child have an IEP or 504 plan? ❑ Yes ❑ No

If so, what accommodations do they receive?_____

FAMILY & HOME

Please indicate the adults your child lives with _____

Does your child spend significant time with anyone else not living in the home? ❑ Yes ❑ No

If yes, explain _____

Has your child ever been through a traumatic family situation (ex: parental loss, divorce, separation, severe parental illness)?

❑ Yes ❑ No *If yes,* at what age? _____

Has anyone in your immediate or extended family been diagnosed with a learning problem? ❑ Yes ❑ No

If yes, who?_____

GENERAL BEHAVIOR

Are there any behavioral concerns at school or at home? ❑ Yes ❑ No

If yes, explain _____

Give us a brief description of your child as a person _____

_____

_____

Name of Parent/Legal Guardian _____ **Today's date** _____

Signature of Parent/Legal Guardian _____