COVD Quality of Life Checklist

Check the column which best represents the occurrence of each symptom

Category	Symptom	Never	Seldom	Occas.	Freq.	Always
A	Blur when looking at near					
A	Headaches with near work					
A	Sees worse at end of the day					
A	Difficulty copying from the Chalkboard					
A	Avoids near work/reading					
A	Holds head too close to the page					
B	Has double vision					
B	Words run together while reading					
B	Eyes burn, itch, or seem watery					
B	Falls asleep while reading					
B	Closes one eye or tilts head while reading					
OR	Dizzy or nauseous with near work					
OR	Writes up or down hill					
OR	Poor/inconsistent in sports					
OR	Avoids sports/games					
OR	Poor hand-eye coordination/poor handwriting					
OR	Clumsy/knocks things over					
OR	Car/motion sickness					
OM	Skips or repeats lines when reading					
OM	Misaligns digits/columns of numbers					
P	Reading comprehension is poor					
P	Trouble keeping attention on reading					
P	Says “I can’t” before trying					
P	Does not use his/her time well					
P	Does not make change well with money					
P	Loses belongings/things					
P	Forgetful/poor memory					
ALL	Difficulty completing assignments on time					
ALL	Does not judge distance accurately					

Your Final Score:

Vision Therapy Questionnaire

Thank you for filling out the following questionnaire CAREFULLY. Please return the form to our office PRIOR to your child's appointment.

General Information

Were you referred? __ Yes __ No

If yes, by whom?__________________________ Phone:________________

Address: ______________________________________

Child's Full Name:___________________________ __ Male __ Female

Birth Date: __ / __ / ____ Age: __ years __ months

Name and Address of School: ____

Grade: __ Teacher: ______________ School Nurse: _____________________ Principal__________________________________

Is your child especially afraid of doctors?__ Yes __ No

Child's handedness: __ Right __ Left

Family Information - those living at home with you

Father: ____ Birth Date: ____ / ____ /________

Mother: ____ Birth Date: ____ / ____ /________

Siblings: ____ Birth Date: ____ / ____ /________

____ Birth Date: ____ / ____/________

____ Birth Date: ____ / ____ /________

____ Birth Date: ____ / ____ /________

____ Birth Date: ____ / ____ /________

Parent Information

Home Address: ____ City: __________________ Zip: _________

Home Phone:______________

Father's Occupation: ___________________________________ Business Phone:______________

Business Address: _____________________________________ City: __________________ Zip: _________

Mother's Occupation:__________________________________ Business Phone:______________

Business Address:______________________________________ City: __________________ Zip: _________

Visual History (if last eye exam performed elsewhere)

Eye Doctor's Name:__________________________________ Date of Visit: ___ /____/____

Reason for Examination:____

Results of Examination:____

Were glasses prescribed? __ Yes __ No Are they worn: __ Yes __ No

If yes, when are they worn?____

Members of the family who have had eye turns or lazy eyes:

Name	Age	Visual Situation

Television Viewing/Handheld Computer Game Use

How much time is spent watching television or playing handheld computer games? ______________________
How often?___________________ Viewing distance for TV? ___________ For handheld game? ____________

Medical History

Physician's Name:____Date of last visit: ___/___/_____
Results of last visit:____
Medications currently using:____
For what condition(s): ____

List illnesses, bad falls, high fevers, etc.:

Age	Condition/Diagnosis	Complications
______	______________________________________	____
______	______________________________________	____
______	______________________________________	____

Is your child generally healthy? __ Yes __No
Are there any chronic problems like ear infections, asthma, hay fever, allergies? __ Yes __No
If yes, please list:____
Has a neurological evaluation been performed? __ Yes __No
If yes, by whom?: Results: ____
Has a psychological evaluation been performed? __ Yes __No
If yes, by whom?: Results:____

Nutritional Information

Current diet: ___Excellent ___Good ___Fair ___Poor
Does your child:
Like sweets? ___ Yes ___No
Crave sweets? ___ Yes ___No
Is your child active?
Moderately? ___ Yes ___No
Extremely? ___ Yes ___No
Are there periods of:
Very high energy? ___ Yes ___No
Very low energy? ___ Yes ___No

Developmental History

Full-term pregnancy? ___ Yes ___No
Normal birth? ___ Yes ___No
Any complications before, during, or immediately following delivery? ___ Yes ___No
Did your child crawl (on stomach on the floor)? ___ Yes ___No
At age: ____
Did you child creep (on stomach off the floor)? ___ Yes ___No
At age: __
Did your child move on "all fours”? ___ Yes ___No
If not, describe:____
At what age did your child walk? ____ Was your child active? ___ Yes ___No
Speech: First words spoken at what age?_____
Was early speech clear to others? ___ Yes ___No
Is it clear now? ___ Yes ___No

Family and Home

Please indicate which adult he/she lives with: __ Mother __ Father __ Stepmother __ Stepfather
__ Foster Parents __ Adoptive Parents __ Grandmother __ Grandfather __ Aunt __ Uncle
__ Other: ____

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness,etc.)? __ Yes __ No

If yes, at what age was your child? __

If yes, does your child seem to have adjusted? __ Yes ____ No

Is your child's family life stable at this time?

How does your child get along with: __ Yes __ No

Parents?____

Siblings? ____

Classmates in school? ____

Playmates at home? ____

Did the child's father or anyone in the father's family have a learning problem? __ Yes __ No

Who?____

Did the child's mother or anyone in the mother's family have a learning problem? __ Yes __ No

Who? ____

Do (or did) any of the other children in the family have learning problems? __ Yes __ No

Who?____

To what extent? ____

____

____

If your child has an Eye Turn (Strabismus)

How old was your child when the eyes began to turn? ___________

At first, was the eye always turned in, or only turned in sometimes? ____________________________

Has the child had surgery for the eye turn? __ Yes __ No

If so, when? ____

Is the eye turning more, or is it stable? ____

Does your child have a head tilt or turn? __ Yes __ No

Which eye turns? __ Right __ Left

Does it turn in or out? __ In __ Out

Has an MRI been performed? __ Yes __ No

If your child has a Lazy Eye (Amblyopia)

How old was your child when the lazy eye was discovered? ________________

Were glasses or contact lenses prescribed for the lazy eye? __ Yes __ No

Which were they? __ Glasses __ Contact Lenses

If so, are they worn? __ Yes __ No

Was patching attempted? __ Yes __ No

How much did the child actually wear the patch?____________________________

Has an MRI been performed? __ Yes __ No

School Information

Age at time of entrance to: _____Kindergarten: _____ First Grade:
Does your child like school? ____ Yes ____No
Has your child changed schools often? ____ Yes ____No
If yes,when? ____
Has a grade been repeated? ____ Yes ____No
If yes,which? ____
Does your child seem to be under tension or extreme pressure when doing school work? ____ Yes _____No
Has your child had any special tutoring and/ or remedial assistance? ____ Yes _____No
If yes,when?____
From whom? ____
Where? ____
How long?____
Result: ____
What school subjects are easy for your child?____
What school subjects are difficult for your child?____
Does your child like to read? ____ Yes ____ No
Voluntarily? Yes ____ No
If your child has trouble reading, did the trouble begin in kindergarten or during 3rd grade or beyond?____________
What does your child like to read? ____
Specifically describe any school difficulties: ____
____
What is your child's attitude toward reading, school, his/her teachers/other youngsters?________________________
____
____
School work is: ____ Above average ____ Average ____ Below Average
Do you feel your child is achieving up to potential? ____ Yes ____ No
Does the teacher feel your child is achieving up to potential? ____ Yes ____ No
What is your child's reading level?____________________________

General Behavior

Are there any behavior problems at school? ____ Yes ____ No
Are there any behavior problems at home? ____ Yes ____ No
What causes these problems? ____
Child's reaction to fatigue? ____ Sag ____ Irritable ____Other:____
Childs reaction ro tension ____ Nail-biting ____ Thumb-sucking Other:____
Does your child say and/or do things impulsively? ____ Yes ____ No
Is your child in constant motion? ____ Yes ____ No
Can your child sit still for long periods? ____ Yes ____ No

Give a brief description of your child as a person: ____
____
____
____
____
____
____

Release of Information

I agree to permit information from, or copies of, my child's examination records to be forwarded to other healthcare providers, teachers, the school district, or professionals upon their written request or upon the recommendation of Fort Myers Eye Associates when it is necessary for the treatment of my child's visual condition.

If records are requested, I authorize their release:

____Date ____ / ___ / _____
(Parent or Guardian Signature)

I give my permission to Fort Myers Eye Associates to treat ____
(Child's name)

____Date ____ / ___ / _____
(Parent or Guardian's Signature)

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to relate the current visual skills to any specific needs.

Thank you,
Dr. Dalesio and Staff
Fort Myers Eye Associates, PA