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EXTENDED QUESTIONNAIRE
Please fill out this questionnaire carefully.

Appointment: Day_____ Date_____ Time _____
Patient's Name: _____
Please plan on arriving to your appointment 10-15 minutes early.

GENERAL INFORMATION
Were you referred to our office? Yes [ ] No [ ]
If yes, whom may we thank for this referral? _____ Phone: _____
Address: _____
Full Name: _____Male _____ Female _____
Emails: _____
Birth Date: _____ Age: _____ years _____ months
Marital Status: Single [ ] Married [ ] Divorced [ ] Widowed [ ]
What is your occupation? _____ Employer: _____
Business Address: _____
Spouse's Name: _____ Occupation: _____
Spouse's Employer: _____ Phone # _____
Business Address: _____
Name and address of patient's school: _____
Grade: _____ Teacher: _____ School Nurse: _____ Principal: _____
Is patient especially afraid of doctors: _____?
Patients dominate hand (circle): right or left? Has guidance been given in use of hand? Yes □ No □

Please list the names and birth dates of your family:
NAME
Father/Caretaker _____ Birth Date _____
Mother/Caretaker _____ Birth Date _____
Sibling _____ Birth Date _____
Sibling _____ Birth Date _____
Sibling _____ Birth Date _____
Sibling _____ Birth Date _____

RESPONSIBLE PERSON INFORMATION
Home Address: _____City: _____ Zip: _____
Home Phone: _____ Other Phone: _____
Father/Caretaker's Occupation: _____ Business Phone: _____
Business Address: _____ City: _____ Zip: _____
Mother/Caretaker's Occupation: _____ Business Phone: _____
Business Address: _____ City: _____ Zip: _____
Do you have Major Medical Insurance: Yes [ ] No [ ]

If so, who is the carrier: _____ Policy #: _____
Name of Insured: _____
Social Security Number: _____ Driver's License #:_____

MEDICAL HISTORY
Doctor's Name: _____ Date of Last Evaluation: _____
For what reason? _____
Results and recommendations: _____
_____
Current state of health: _____
Medications currently using, including vitamins and supplements: _____
_____
For what condition(s)? _____
_____
Immunizations patient had received:
Immunization type: _____ Date: _____
Immunization type: _____ Date: _____
Immunization type: _____ Date: _____
Immunization type: _____ Date: _____
Any reactions to immunization(s)? Yes [ ] No [ ] if yes, explain: _____

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

Age	Severe	Mild	Complications

Is patient generally healthy? Yes [ ] No [ ]
If no, explain: _____
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 [ ]
By whom? _____ Results and recommendations: _____
_____
Has a psychological evaluation been performed? Yes [ ] No [ ]
By whom? _____ Results and recommendations: _____
_____
Has an occupational therapy evaluation been performed? Yes [ ] No [ ]
By whom? _____ Results and recommendations: _____
_____

Is there any history of the following? (Please check if there is a history)

	Patient	Family	Who		Patient	Family	Who
Diabetes	[ ]	[ ]	_____	Multiple Sclerosis	[ ]	[ ]	_____
"Cross" or "Wall" eye	[ ]	[ ]	_____	Epilepsy or Seizures	[ ]	[ ]	_____
Chromosomal Imbalance	[ ]	[ ]	_____	Other	[ ]	[ ]	_____
				If other, please explain: _____			

Glaucoma	[ ]	[ ]	_____	_____
High Blood Pressure	[ ]	[ ]	_____	_____
Learning Disability	[ ]	[ ]	_____	_____
Amblyopia (lazy eye)	[ ]	[ ]	_____	_____

NUTRITIONAL INFORMATION

Current Diet: Excellent [ ] Good [ ] Fair [ ] Poor [ ]
Does your patient: Like sweets [ ] or crave sweets [ ]
If yes, what types? _____
Is patient active? Yes [ ] No [ ]
Moderately? Yes [ ] No [ ]
Extremely? Yes [ ] No [ ]
Are there periods of?
Very high energy? Yes [ ] No [ ]
Very low energy? Yes [ ] No [ ]
Explain: _____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes [ ] No [ ]
Did the mother experience any health problems during the pregnancy? Yes [ ] No [ ]
If yes, please explain: _____
Normal birth? Yes [ ] No [ ]
Any complications before, during, or immediately following delivery? Yes [ ] No [ ]
If yes, please explain: _____
Birth weight: _____ APGAR scores @ birth: _____ After 10 minutes: _____
Were forceps used? Yes [ ] No [ ]
Was there ever any reason for concern over patient's general growth or development?
Yes [ ] No [ ]
If yes, why? _____
Did patient crawl (stomach on floor)? Yes [ ] No [ ] at what age? _____
Did patient creep (on all fours)? Yes [ ] No [ ] at what age? _____
If not, describe: _____
At what age did patient walk? _____
Was patient active? Yes [ ] No [ ]
Speech: First words: _____ At what age: _____
Was early speech clear to others? Yes [ ] No [ ]
Is speech clear now? Yes [ ] No [ ]

VISUAL HISTORY

Has patient's vision been previously evaluated? Yes [ ] No [ ]
Is so, Doctor's Name: _____ Date of last evaluation: _____
Reason for examination: _____
Results and recommendations: _____
Were glasses, contact lenses, or other optical devices recommended? Yes [ ] No [ ]
If yes, what? _____

Are they used? Yes [ ] No [ ] If yes, when? _____
If not used, why not? _____

Members of the family who have had visual attention and the reason:

Name	Age	Visual Situation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PRESENT SITUATION

Why do you feel patient needs a visual evaluation? _____
_____
How long has this problem/difficulty been observed? _____
Is there any evidence from the school, psychological, or other tests that indicates some visual malfunction may be present? Yes [ ] No [ ]
If yes, what? _____
_____

Does patient report any of the following?	Yes	No	If yes, when?
Headaches	[ ]	[ ]	_____
Blurred vision/focus goes in and out	[ ]	[ ]	_____
Double Vision	[ ]	[ ]	_____
Eyes hurt	[ ]	[ ]	_____
Eyes tired	[ ]	[ ]	_____
Words move around on the page	[ ]	[ ]	_____
Motion sickness/car sickness	[ ]	[ ]	_____
Dizziness	[ ]	[ ]	_____

List any other complaints your child makes concerning his/her vision? _____
_____

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING:

	Yes	No	If yes, when?
Eyes frequently reddened	[ ]	[ ]	_____
Frequent eye rubbing	[ ]	[ ]	_____
Frequent sties	[ ]	[ ]	_____
Frowning	[ ]	[ ]	_____
Bothered by light	[ ]	[ ]	_____
Frequent blinking	[ ]	[ ]	_____
Closing or covering one eye	[ ]	[ ]	_____
Difficulty seeing distant objects	[ ]	[ ]	_____
Head close to paper when reading or writing	[ ]	[ ]	_____
Avoids reading	[ ]	[ ]	_____
Prefers being read to	[ ]	[ ]	_____

Tilts head when reading	[ ]	[ ]	_____
Tilts head when writing	[ ]	[ ]	_____
Moves head when reading	[ ]	[ ]	_____
	Yes	No	If yes, when?
Confuses letter or words	[ ]	[ ]	_____
Reverses letter or words	[ ]	[ ]	_____
Skips, rereads or omits words	[ ]	[ ]	_____
Loses place while reading	[ ]	[ ]	_____
Vocalizes when reading silently	[ ]	[ ]	_____
Reads slowly	[ ]	[ ]	_____
Uses finger as a marker	[ ]	[ ]	_____
Poor reading comprehension	[ ]	[ ]	_____
Comprehension decreases over time	[ ]	[ ]	_____
Writes or prints poorly	[ ]	[ ]	_____
Writes neatly but slowly	[ ]	[ ]	_____
Does not support paper when writing	[ ]	[ ]	_____
Awkward or immature pencil grip	[ ]	[ ]	_____
Frequent erasures	[ ]	[ ]	_____
Tires easily	[ ]	[ ]	_____
Difficulty copying from chalkboard	[ ]	[ ]	_____
Difficulty recognizing same word	[ ]	[ ]	_____
On different page	[ ]	[ ]	_____
Poor word attack skills	[ ]	[ ]	_____
Difficulty with memory	[ ]	[ ]	_____
Remembers better what hears then sees	[ ]	[ ]	_____
Responds better orally than by writing	[ ]	[ ]	_____
Seems to know material, but does			
Poorly on tests	[ ]	[ ]	_____
Dislikes/avoids near tasks	[ ]	[ ]	_____
Short attention span/loses interest	[ ]	[ ]	_____
Poor large motor coordination	[ ]	[ ]	_____
Poor fine motor coordination	[ ]	[ ]	_____
Difficulty with scissors/small hand tools	[ ]	[ ]	_____
Dislikes/avoids sports	[ ]	[ ]	_____
Difficulty catching/hitting a ball	[ ]	[ ]	_____

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Does patient watch TV? Yes [ ] No [ ]

How much? _____How often? _____Viewing Distance? _____

Does patient spend time using computer/video games? Yes [ ] No [ ]

If yes, how much? _____ how often? _____ Viewing Distance? _____

What other activities occupy patient's leisure time? _____

Are there any activities patient would like to participate in, but doesn't? _____

Please explain: _____

_____

SCHOOL

Age at time of entrance to: Pre-school _____ Kindergarten _____ First Grade _____
Does patient like school? Yes [ ] No [ ]
Specifically describe any school difficulties: _____
_____
Has your patient changed schools often? Yes [ ] No [ ]
If yes, when? _____
Has a grade been repeated? Yes [ ] No [ ]
If yes, which and why? _____
Does patient seem to be under tension or extreme pressure?
When doing school work? Yes [ ] No [ ]
Has patient had any special tutoring, therapy, and/or remedial assistance? Yes [ ] No [ ]
If yes, when? _____
Where and from whom? _____
How long? _____
Results: _____
Does your patient like to read? Yes [ ] No [ ]
Voluntarily? Yes [ ] No [ ]
Does patient read for pleasure? Yes [ ] No [ ]
What? _____
What is patient's attitude toward reading, school, his/her teachers, other youngsters? _____
_____
Overall schoolwork is: above average [ ] average [ ] below average [ ]
WHICH SUBJECTS ARE:
Above average: _____
Average: _____
Below average: _____
Does patient need to spend a lot of time/effort to maintain this level of performance?
Yes [ ] No [ ]
How much time on average does patient spend each day on homework assignments? _____
To what extent do you assist patient with homework? _____
Do you feel patient is achieving up to potential? Yes [ ] No [ ]
Does the teacher feel patient is achieving up to potential? Yes [ ] No [ ]

EMPLOYMENT OR SCHOOL

Current position: _____ Major course of study: _____
How many hours daily do you spend at a desk? _____
How many hours daily do you spend reading or studying? _____
How many hours daily do you spend working at near distances? _____
Do you feel you are achieving to your potential in work or school? Yes [ ] No [ ]
Do you feel you are getting adequate return for the amount of effort you put into a task? Yes [ ] No [ ]
If no, please explain: _____
Does your work or course of study demand comprehension from the written word? Yes [ ] No [ ]
Describe briefly your daily activities at work or in school: _____
_____

GENERAL BEHAVIOR

Are there any behavior problems at school? Yes [ ] No [ ]
If yes, what? _____
Are there any behavior problems at home? Yes [ ] No [ ]
If yes, what? _____
What causes these problems? _____
Patient's reaction to fatigue? Sag [ ] irritable [ ] other [ ] _____
Patient's reaction to tension? Avoidance [ ] irritable [ ] other [ ] _____
Does patient say and/or do thing impulsively? Yes [ ] No [ ]
Is patient in constant motion? Yes [ ] No [ ]
Can patient sit still for long periods? Yes [ ] No [ ]

HOBBIES/SPORTS

Describe the types of activities that comprise the majority of your leisure time: _____
_____
_____
Do you watch TV? Yes [ ] No [ ]
If yes, how many hours per day? _____
How many hours per week? _____
Are you seriously involved with athletics? Yes [ ] No [ ]
Do you feel you are achieving up to your potential in sports/athletics? Yes [ ] No [ ]
Of all the sports you have played:
List the ones in which you excel: _____
List the ones in which you do poorly/avoid: _____

FAMILY AND HOME

Please indicate which adult(s) patient lives with? Mother [ ] Father [ ] Stepmother [ ]
Stepfather [ ] Foster Parents [ ] Adoptive Parents [ ] Grandmother [ ] Grandfather [ ]
Aunt [ ] Uncle [ ] Other Caretaker (please specify): _____
Does patient spend time with any other person, not in the home? Yes [ ] No [ ]
Please explain: _____
Has patient ever been through a traumatic family situation (such as a divorce, parental loss?
Separation, sever parental illness)? Yes [ ] No [ ]
If yes, at what age: _____
Does patient seem to have adjusted? Yes [ ] No [ ]
Was counseling/therapy undertaken? Yes [ ] No [ ]
If yes, is it on-going? Yes [ ] No [ ]
If family life stable at this time? Yes [ ] No [ ]
If no, please explain: _____
How does patient get along with?
Parents/other caretakers? _____
Siblings? _____
Classmates in school? _____
Playmates at home? _____

Did father or anyone in father's family have a learning problem? Yes [ ] No [ ]
If yes, who? _____
Did mother or anyone in mother's family have a learning problem? Yes [ ] No [ ]
If yes, who? _____
Do any, or did any, of the children in the family have learning problems? Yes [ ] No [ ]
If yes, who? _____
To what extent? _____
_____
_____

GIVE A BRIEF DESCRIPTION OF PATIENT AS A PERSON: _____
_____
_____
_____
_____
_____

IS THERE ANY INFORMATION YOU FEEL WOULD BE HELPFUL/IMPORTANT IN OUR TREATMENT OF PATIENT? _____
_____
_____
_____
_____
_____
_____
_____
_____

RELEASE OF INFORMATION AND INSURANCE FILING

IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH YOUR CHILD'S SCHOOL AND/OR OTHER HEALTH CARE PROVIDERS OR INSURANCE CARRIERS UPON THEIR WRITTEN REQUEST OR UPON THE RECOMMENDATION OF DOCTOR SHERMAN WHEN IT IS NECESSARY FOR THE TREATMENT OF MY CHILD'S VISUAL CONDITION, OR FOR THE PROCESSING OF INSURANCE CLAIMS. I AUTHORIZE DR. SHERMAN TO EXCHANGE INFORMATION WITH MY CHILD'S SCHOOL AND OTHER PROFESSIONALS INVOLVED IN MY CHILD'S CARE, BY MEANS OF MY SIGNATURE BELOW. THIS AUTHORIZATION SHALL BE CONSIDERED VALID THROUGHOUT THE DURATION OF TREATMENT.

_____ _____
SIGNATURE DATE

_____
RELATIONSHIP TO PATIENT

I HEREBY GIVE MY PERMISSION TO DR. SHERMAN TO TREAT _____.
PATIENT

_____ _____
PARENT'S OR GUARDIAN'S SIGNATURE DATE

THANK YOU FOR CAREFULLY COMPLETING THIS QUESTIONNAIRE. THE INFORMATION SUPPLIED WILL ALLOW FOR A MORE EFFICIENT USE OF TIME AND WILL ENABLE US TO PERFORM A MORE COMPREHENSIVE EVALUATION OF YOUR CHILD AND TO BETTER MEET YOU CHILD'S SPECIFIC VISUAL NEEDS.

IF YOU HAVE ANY QUESTIONS OR CONCERNS THAT WE MAY ANSWER PRIOR TO YOUR APPOINTMENT, PLEASE DO NOT HESITATE TO CONTACT US.

YOU MAY LEAVE A MESSAGE FOR US 24 HOURS A DAY / 7 DAYS A WEEK. WE REQUEST A MINIMUM OF 24 HOURS NOTICE IF YOU ARE UNABLE TO KEEP THIS APPOINTMENT.

PLEASE BE ON TIME FOR YOUR EXAMINATION, SO THAT WE WILL HAVE THE MAXIMUM OPPORTUNITY TO EVALUATE YOUR CHILD'S VISUAL STATUS.

THANK YOU.

MARC H. SHERMAN, O.D., F.C.O.V.D.