

Vision Screening Parent Questionnaire: Part I

Child's Name _____ D.O.B. _____

Date of Screening _____ Child's Age at Screening _____

School District / BOCES: _____

Evaluator _____ Site of Screening _____

If information has not been gathered through the Child Find Intake Form that addresses possible high risk conditions for visual problems, this form may be used as part of the parent interview process.

General History: High Risk Populations for Visual Problems

	Yes	No
Is there a family history of early onset vision loss (e.g., cataracts, albinism)?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a family history of vision problems such as eye crossing, color vision problems, and/or needing glasses?	<input type="checkbox"/>	<input type="checkbox"/>
Was your child exposed to any prenatal infections (e.g. rubella, toxoplasmosis, cytomegalovirus)?	<input type="checkbox"/>	<input type="checkbox"/>
Did your baby weigh less than three pounds at birth?	<input type="checkbox"/>	<input type="checkbox"/>
Was your child born prematurely?	<input type="checkbox"/>	<input type="checkbox"/>
Was your child exposed to alcohol or drugs before birth?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child had meningitis or encephalitis?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child experienced some form of head trauma?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have a seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have any difficulties with his or her hearing?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child been diagnosed with a syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child been diagnosed as having cerebral palsy?	<input type="checkbox"/>	<input type="checkbox"/>

Vision Screening Parent Questionnaire: Part II

Please complete this section of the Parent Questionnaire to either supplement the Child Find Intake information and/or the Part 1 portion.

1. Do you have any concerns about your child's vision? If yes, please describe.

2. If your child has motor coordination problems, do you feel these difficulties are tied to poor vision (e.g., not seeing steps or slight changes in floor surfaces)?

3. Has your child ever been seen by an eye doctor (optometrist or ophthalmologist?)

No _____

Yes _____ If yes, when: _____

If yes, what were the results of the exam? _____

4. Were glasses or another treatment prescribed?

No _____

Yes _____ If yes, does your child wear the glasses? Yes ____ No ____

5. If glasses were prescribed, is the child wearing the glasses today? Yes ____ No ____

6. If not, what is the reason the child is not wearing his or her glasses: