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

Is there a family history of early onset vision loss (e.g., cataracts, albinism)?

☐ Yes  ☐ No

Is there a family history of vision problems such as eye crossing, color vision problems, and/or needing glasses?

☐ Yes  ☐ No

Was your child exposed to any prenatal infections (e.g. rubella, toxoplasmosis, cytomegalovirus)?

☐ Yes  ☐ No

Did your baby weigh less than three pounds at birth?

☐ Yes  ☐ No

Was your child born prematurely?

☐ Yes  ☐ No

Was your child exposed to alcohol or drugs before birth?

☐ Yes  ☐ No

Has your child had meningitis or encephalitis?

☐ Yes  ☐ No

Has your child experienced some form of head trauma?

☐ Yes  ☐ No

Does your child have a seizure disorder?

☐ Yes  ☐ No

Does your child have any difficulties with his or her hearing?

☐ Yes  ☐ No

Has your child been diagnosed with a syndrome?

☐ Yes  ☐ No

Has your child been diagnosed as having cerebral palsy?

☐ Yes  ☐ No
**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: