

Dr. Emily Schottman
Developmental Optometrist

Summer Beathe
Vision Therapist



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DEVELOPMENTAL VISION EVALUATION QUESTIONNAIRE - YOUNG ADULT

Thank you for carefully completing this questionnaire.

Please return it to our office one week before your appointment by email or regular mail.

Appointments without a questionnaire submitted will need to be rescheduled.

Patient's Name: _____ Developmental Vision Evaluation Date: _____ Time: _____

Date of Birth: _____ Age: __ yrs. Gender: Male Female Were you referred to us? Yes No

If you were referred, whom may we thank? _____

Referral Type: Doctor Therapist Tutor/Teacher Family Friend Other: _____

If not referred, how did you hear about us? _____

PATIENT'S CONTACT INFORMATION

Home Phone: _____ Home Address: _____

City: _____ Zip: _____ Patient's Cell Phone: _____

Mother/Caretaker's Name: _____ Email: _____

Occupation: _____ Business Phone: _____ Cell Phone: _____

Father/Caretaker's Name: _____ Email: _____

Occupation: _____ Business Phone: _____ Cell Phone: _____

PATIENT'S MEDICAL HISTORY

Pediatrician's Name: _____ Is the patient especially afraid of doctors? Yes No

Last Visit Date: _____ For what reason? _____ Is the patient generally healthy? Yes No

Medications (include vitamins/supplements): _____

Has the patient been immunized? Yes No Are the immunizations up-to-date? Yes No

List below any significant illnesses, bad falls, high fevers or chronic illnesses (asthma, allergies, frequent colds, ear infections).

Event/Condition	Age	Severity	Describe any complications

PATIENT'S FAMILY HISTORY (Please check if there is any history of the following.)

	<u>Patient</u>	<u>Family</u>	<u>If Family, Who?</u>		<u>Patient</u>	<u>Family</u>	<u>If Family, Who?</u>
Poor Vision/Hi Rx	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strabismus/ eye turn	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning Issue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

VISUAL HISTORY-EXTENDED

Why do you feel the need for a Visual Evaluation? _____

How long has this problem/difficulty existed? _____

Do you feel vision hinders daily activities in any way? Yes No

If yes, explain: _____

Do you feel vision limits potential in any way? Yes No If yes, explain: _____

Has Vision Therapy or Vision Training occurred? Yes No Doctor's Name and City: _____

Please describe the age at which started, how long participated and an estimate of results: _____

Is there any evidence from the school, psychological, or other tests that indicates some visual issue may be present?

Yes No If yes, what? _____

Do you notice any of the following? (Note: many of these symptoms fall into more than one category)

Prescription/ Eye Focusing (Accommodation) Problem

- Blurry vision
- Difficulty focusing near/far (taking notes in class)
- Eyestrain, fatigue, headaches
- Red eyes or lids
- Excessive watering of eyes
- Head close to paper when reading/writing
- Reading comprehension decreases with time

Eye Tracking (Ocular Motility) Problem

- Skip words when reading
- Must reread to understand, especially when tired
- Use finger or marker when reading
- Loses place when reading
- Head movements when reading

Eye Teaming (Binocularity) Problem

- See double, especially when tired
- Cover or close one eye when reading or writing
- Tilt or turn your head
- Poor posture
- Awkward position or head on arm to read/write
- Squint or Rub eyes
- Letters or lines "float" "run together," or "jump around"
- Eyestrain or fatigue, especially at end of day

Visual Motor Problem

- Write or print poorly (crooked, poor spacing, up/down)
- Writes neatly but slowly
- Awkward pencil grip
- Poor eye-hand coordination
- Clumsy, accident-prone
- Difficulty judging distances or objects
- Dislike/avoid sports

Visual Information-Processing Problem

- Slow reader
- Confuses letters or words
- Difficulty recognizing same word on different page
- Mistakes words with similar beginnings
- Poor ability to remember what is read
- Seems to know material but does poorly on tests
- Reverses letters and numbers
- Learn better when "hear" the information
- Vocalize or move lips when reading silently
- Difficulty remembering directions
- Poor time management, always running behind
- Poor printing or handwriting
- Short attention span, distractible or loss of interest
- Confuse "right" and "left" directions
- Short attention span / loss of interest
- Difficulty attending to detail

DEVELOPMENTAL HISTORY

Was the patient born prematurely? Yes No Birth weight: _____ Apgar scores@ birth: _____ After 10 minutes: _____

Any pregnancy/delivery complications? Yes No If yes, explain: _____

Did the patient creep (stomach on floor)? Yes No At what age? _____ Anything unusual? _____

Did the patient child crawl (stomach off floor)? Yes No At what age? _____ Anything unusual? _____

At what age did the patient walk? _____ Speech: First words: _____ At what age: _____

Was early speech clear to others? Yes No Is speech clear now? Yes No

Patient's dominant hand? Right Left Unknown Has guidance been given in use of hand? Yes No

Has there been any concern over the patient's general growth or development? Yes No

If yes, explain: _____

Have any of the following evaluations been performed?

Neurological evaluation? Yes No By whom? _____

Results and recommendations: _____

Psychological evaluation? Yes No By whom? _____

Results and recommendations: _____

Occupational therapy evaluation? Yes No By whom? _____

Results and recommendations: _____

THE PATIENT'S SCHOOL AND READING HABITS

Age at time of entrance to: Pre-school ____ Kindergarten ____ First Grade ____ Current School Grade: ____

School Name: _____

Teacher Name: _____ School Nurse Name: _____

Principal Name: _____ In-School Educational Specialist Name: _____

Has the patient changed schools often? Yes No If yes, when? _____

Has a grade been repeated? Yes No If yes, which and why? _____

Does the patient like school? Yes No What parts? _____

Specifically describe any school difficulties: _____

Does the patient seem to tense up when doing school work? Yes No

Has the patient had any special tutoring, therapy, and/or remedial assistance? Yes No

If yes, when? _____

Where and from whom? _____

How long? _____

What were the results: _____

Does the patient like to read? Yes No Does the patient read voluntarily? Yes No

If yes, what? _____

What is the 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 the patient need to spend a lot of time/effort to maintain this level of performance? Yes No

How much time on average does the patient spend each day on homework assignments? ____ hours

To what extent do you assist the patient with homework? _____

Do you feel the patient is achieving up to potential? Yes No

Does the teacher feel the patient is achieving up to potential? Yes No

THE PATIENT'S 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? sad irritable other _____

Patient's reaction to tension? avoidance irritable other _____

Does the patient say and/or do things impulsively? Yes No Can the patient sit still for long periods? Yes No

What best describes the patient's activity level? Inactive Moderately active Extremely active

Explain: _____

THE PATIENT'S TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Does child watch TV? Yes No Average viewing time? _____ # of times a week? _____ Viewing distance? _____

Use computer? Yes No Average viewing time? _____ # of times a week? _____ Viewing distance? _____

Play video games? Yes No Average viewing time? _____ # of times a week? _____ Viewing distance? _____

What other activities occupy the patient's leisure time? _____

Are there any activities the patient would like to participate in, but doesn't? Yes No

Please explain: _____

THE PATIENT'S NUTRITIONAL INFORMATION

Current Diet: Excellent Good Fair Poor

Does the patient: Like sweets or Crave sweets If yes, what types? _____

Has the patient tested positive for Food Allergies? If so, which foods? _____

THE PATIENT'S FAMILY AND HOME

Please indicate which adult(s) he/she lives with? Mother Father Stepmother Stepfather Foster Parents

Adoptive Parents Grandmother Grandfather Aunt Uncle Other Caretaker: _____

Does the patient spend a significant amount of time with any other person, not in the home? Yes No

Please explain: _____

Does the patient have any siblings? Yes No Names and ages? _____

Has the patient ever been through a traumatic family situation (separation/divorce, parental loss, separation from parents, severe parental illness)? Yes No Please explain: _____

If yes, at what age: _____ Does the patient seem to have adjusted? Yes No

Was counseling /therapy undertaken? Yes No If yes, is it on-going? Yes No

Is family life stable at this time? Yes No If no, please explain: _____

Does the patient get along well with: Parents/other caretakers? Yes No Siblings? Yes No

Classmates in school? Yes No Playmates at home? Yes No

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

WHAT ARE YOUR BIGGEST CONCERNS REGARDING THE PATIENT AT THIS TIME? _____

WHAT IS THE GOAL FOR THE PATIENT'S VISUAL EVALUATION AND/OR VISION TRAINING?

If you have any questions or concerns that we may answer prior to the 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. *There is a \$45 rescheduling fee to reappoint a missed appointment.*

Please be on time for the appointment, so that we will have the maximum opportunity to evaluate the patient's vision.
Please do not bring any other children with you because your undivided attention is necessary during the evaluation.

We are looking forward to meeting you.

Thank you.



Dr. Emily Schottman
Developmental Optometrist

Developmental Optometrists specialize in the testing and training of visual skills used for improved performance in school, work and sports/hobbies, providing a more enjoyable quality of life.

STRABISMUS/AMBLYOPIA ADDENDUM

(Please complete if applicable)

Have you ever been told that the patient has amblyopia ("lazy eye")? Yes No If Yes, at what age? _____

Have you ever been told that the patient has strabismus ("lazy eye")? Yes No If Yes, at what age? _____

Has the patient had an eye surgery? Yes No

Please describe the surgery, including the age surgery was performed, the number of operations, the eye(s) operated on: _____

Was the surgeon satisfied with the results of surgery? Yes No Explain: _____

Were you satisfied with the results of surgery? Yes No Explain: _____

Have surgical results been maintained? Yes No Explain: _____

Are you here for a second opinion regarding surgery or other treatment? Yes No

IF THE PATIENT'S EYE TURNS:

- At what age did you first notice or suspect that was an eye turning? _____
- Did it begin turning suddenly or gradually ? Explain: _____
<NOTE: A SUDDEN EYE TURN MAY BE DUE A SERIOUS MEDICAL CONDITION AND REQUIRES IMMEDIATE MEDICAL ATTENTION>.
- Does the eye turn in , out , up , or down ? (check all that apply)
- Is the eye turn getting worse or better or is there no change ?
- Is it always the same eye that turns? Yes No If yes, which eye? Right Left
- Is the eye turn always present? Yes No If no, under what conditions is it present? _____
- Does the eye always turn the same amount? Yes No If no, explain: _____
- Do you notice if the eye turns more when the patient is looking:
 - up close? Yes No
 - in the distance? Yes No
 - to the left? Yes No
 - to the right? Yes No
 - up? Yes No
 - down? Yes No

Does the eye turn less (or vision improve) when the prescription is worn? Yes No Unsure

Has the patient ever used an eye patch? Yes No

If Yes, please describe your age when the patching was started, how the patching was done and for how long, the eye patched, and an estimate of the results: _____

Does one pupil ever appear to be larger than the other? Yes No

Do you ever notice one or both eyes shaking rapidly? Yes No

What is the patient's best corrected vision, if known? _____

What are your biggest concerns regarding the patient's Strabismus or Amblyopia? _____

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RELEASE OF INFORMATION

IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH THE PATIENT'S SCHOOL AND/OR OTHER PROFESSIONALS INVOLVED IN HIS/HER CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I agree to permit information from, or copies of, my child's examination records to be forwarded to my child's school, other health care providers or insurance carriers upon their written request or upon the recommendation of the STARS IN YOUR EYES OPTOMETRY when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I authorize Dr. Emily Schottman and STARS IN YOUR EYES OPTOMETRY 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 STARS IN YOUR EYES OPTOMETRY to treat _____.
(Child's Name)

Parent's or Guardian's Signature

Date