Michael Smith Optometry
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Health and Developmental Questionnaire

Date of initial appointment……/……/……

Please complete and return
The information given in this questionnaire is confidential. Please answer as many questions as possible, as this information will assist us in helping you or your child. If you do not know the answers to any of the following questions, they can be discussed during your appointment.

CHILD'S NAME……..DATE OF BIRTH……../……/……

ADDRESS…….

……..POSTCODE……..

TEL NO……..EMAIL……..

CARE GIVER 1 NAME……CARE GIVER 2 NAME…….

PARENT/CAREGIVER OCCUPATIONS

CAREGIVER 1……..WORK NO……

CAREGIVER 2……..WORK NO……

HOW DO YOU WISH TO BE CONTACTED (please circle)

PHONE SMS EMAIL

MEDICARE NUMBER……..POSITION ON CARD……EXPIRY……

PARENT/CAREGIVER CLAIMANT DETAILS
NAME……..D.O.B…….
MEDICARE NUMBER……..POSITION ON CARD……EXPIRY……

Does the child live with both parents/caregiver YES NO, if no

how much time with parent/caregiver 1 ……

how much time with parent/caregiver 2……

SCHOOL ATTENDED…….GRADE/YEAR……

FROM WHOM DID YOU HEAR OF OUR SERVICES……..

Areas of difficulty

Child's present area of difficulty

Reading □ writing □ spelling □ no definite preferred hand □

Co-ordination □ speech □ behaviour □ delayed development □

Concentration □ any other problems……

Family history

Any family and/or relative with

Reading problems □ Ambidextrous □ Left handed □ Poor co-ordination □ similar problem to child □

SIBLINGS:

Name age position in family handedness

……

……

……

……

Birth history

PREGNANCY did mother have any of the following during pregnancy:

Infectious disease □ severe trauma □ high blood pressure □ toxaemia □
medication □ oedema □ haemorrhage □ Pregnancy difficult to maintain □

Did mother smoke during pregnancy □

other……

Gestation.....weeks……

BIRTH length of labour (hrs)……Birth weight……

Was labour…… normal □ induced □ assisted □ caesarean □

Were instruments used Yes □ No □

Was anaesthesia used none □ general □ local □ spinal □

Type of presentation head □ breech □ feet first □

Describe any birth complications……

Post natal history

	YES	NO
Was baby well at birth	□	□
Did baby have difficulty crying or breathing after birth	□	□
Did baby have any difficulty sucking in first 24hrs	□	□
Did baby require any intervention in first 24hrs	□	□

If yes please describe……

Was baby bottle fed	□	□
If breast fed – how long……		
Was disposition of baby abnormal	□	□
Was feeding difficult to establish	□	□
Did baby fail to regain birth weight by 5 days	□	□
Did baby have jaundice	□	□
Did baby have any sleeping difficulties in first 6 months	□	□
Did baby have any feeding difficulties in first 6 months	□	□

Developmental History

	YES	**NO**
Did baby object to lying on their front	□	□
Did he/she seem too active to you	□	□
Did he/she seem too inactive/lack curiosity to you	□	□
Was child slow learning to roll over (more than 6 months)	□	□
Did child **omit** stage of moving on floor on their tummy	□	□
Was child propped to learn to sit	□	□
Was he/she **unable** to sit alone at 8 months	□	□
Did he/she shuffle around on their bottom	□	□
Did he/she **NOT** crawl on hands and knees	□	□
Did he/she walk **before** 10 months	□	□
Did he she walk **after** 18 months	□	□
Was walking clumsy for a long time	□	□
Did he/she spend more than 1-2hrs daily in a playpen	□	□
Did he/she spend more than 1-2hrs daily in a walker	□	□

Motor skills

Do you consider your child has poor motor co-ordination	□	□
Was your child unable to learn to run, hop, jump, skip easily	□	□
Was your child late to develop a preferred hand (after 2 ½)	□	□
Is he/she poor at ball games (catching/hitting) or at sports	□	□
Do you consider he/she has poor balance	□	□

Hearing and speech	**YES**	**NO**
Are you concerned about his/her hearing	□	□
Is her she sensitive/upset by loud noises	□	□
Was development of speech considered abnormal	□	□

Does he/she have difficulty expressing themselves fluently	□	□
Has your child had a hearing test	□	□
If yes, was hearing normal	□	□

General Development

As an infant did he/she object to being cuddled	□	□
Does he/she appear to have a **high** pain tolerance	□	□
Does he/she appear to have a **very low** pain tolerance	□	□
As an infant was he/she upset by movement/play	□	□
As an infant did he/she lack a sense of adventure	□	□
Was his/her sense of danger poorly developed by age 2	□	□
Was he/she a climber extraordinaire	□	□
Does he/she continue to have minor accidents(falls, bumps)	□	□
Did he/she have difficulty learning left from right by age 6	□	□
Does he/she get car sick	□	□
Does he/she touch everything especially when in new places	□	□
Is he/she always asking questions	□	□

Personality

Please tick appropriate conditions

Easy to anger □ Impulsive □ Short attention span □ Lacks confidence □ Over active □ Underactive □ Tries hard □ Gives up easily □ Stubborn □ Dependent □ Self sufficient □ Easily excited □ Overly sensitive emotionally □ Easily lead by others □

Schooling

Does your child like going to school…….. yes □ no □

Does your child have a behaviour problem at school……yes □ no □

If yes, please describe…….

…….

…….

How does your child get on with classmates - Liked □ a clown □ a loner □ a leader □ a bully □

Has your child had any of the following ? please tick

Special remedial help (eg Reading Recovery) □ Psychological testing □

Has your child repeated a grade yes □ no □

Nutrition & diet

What beverages does he/she like to drink ?.....

What vegetables and fruit does he/she like to eat ?.....

……

What vegetables/fruit does he/she dislike……..

……

List the foods he/she likes most……

……..

List foods he/she dislikes most……..

……

How often per week does he/she have

Lollies……Milk shakes……Sweet biscuits…….. Softdrinks…….Icecreams……

Potato chips…… Cordials ……..Cakes/donuts……White bread……

Typical daily diet

On rising……..

Breakfast……

Mid morning……..

Lunch……

Mid afternoon……..

Dinner……

Evening……..

Medical History

Please tick any conditions below that your child has suffered:

Infectious diseases

Measles □ Mumps □ Chicken pox □ Glandular fever □ German Measles □ Whooping cough □ others……..

Other infections

Repeated 'colds' □ Glue ear □ Ear aches □ Middle ear infections □ Frequent sore throats □ Tonsillitis □ Bronchitis □ Pneumonia □ Meningitis □ Encephalitis □ Urinary tract infections □ High temperatures of unknown origin □

Allergies

Persistently blocked nose □ Snuffly baby □ Hay fever □ Asthma □ Sinusitis □ Eczema □

Known food allergies (please list)……..

……..

Other allergies (please list)……

……..

Abnormal reactions to immunisations yes □ no □

Any of the following

Convulsions □ Epilepsy □ Chronic diarrhoea □ Constipation □ Obesity □ Poor appetite □ Lack of energy □ Excessive sweating □

Injury

Head injury □ Concussion □ Broken bones □ Poisoning □

Other (please explain) ……..

Disorders of

Blood □ Kidneys □ Heart □ Lungs □ Gastrointestinal tract □

Medication

Is your child on any medication yes □ no □

If so please detail……..

Other Professionals

Please list any other specialists/consultants seen eg vision, auditory, speech pathologist, occupational therapist, osteopath, chiropractor, podiatrist etc

Date Institution/consultant Speciality Results

……..

……..

……..

……..

……..

List hospitalization, if any, giving age at which occurred and reason

……..

……..

……

Any other information you may consider relevant

……
……

Visual History

Does one eye turn in or out ? **Yes** □ **No** □

If yes, when was this first noticed ?.....How often is turn noticed ?.....

When is turn noticed, eg when eating, drawing etc. ?.....

Has child had any previous visual examination ? **Yes** □ **No** □

If yes, when was the last examination ? ……

Were glasses prescribed ? **Yes** □ **No** □

Has patching of one eye been prescribed ? **Yes** □ **No** □

If yes, how long was patch worn ?.....

Does child dislike bright light especially when outside ? **Yes** □ **No** □

Does child screw up one eye when in bright light ? **Yes** □ **No** □

Tick the box next to any problem that seems to occur often for your child.

Signs of Focusing and Eye Teaming Problems

Covers or closes one eye when reading		Complains of words moving on the page	
Complains of eyestrain		Inattentive	
Complains of headache		Poor reading comprehension	
Complains of double vision		Loses place when reading	
Complains of blurred vision when reading		Complains of blurred vision looking from desk to board	
Rubs eyes		Holds book very close	

Signs of Tracking Problems

Loses place often		Uses finger to keep place	
Skips words and lines often		Short attention span when reading	

Signs of Visual Processing Disorders

Trouble learning left and right		Untidy writing	
Reverses letters and numbers		Trouble copying from border to book	
Mistakes words with similar beginnings		Doesn't recognise the same word repeated on a page	
Poor recall of visually presented material		Trouble with spelling and sight word vocabulary	
Slow copying and completing worksheets		Seems to know material, but does poorly on written tests	
Can respond orally, but not in writing		Erases excessively	
Trouble learning basic math concepts of size and magnitude		Poor reading comprehension yet good comprehension when listening	