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	