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InDepth Vision
VISION THERAPY AND REHABILITATION

MYOPIA QUESTIONNAIRE

Please fill out this questionnaire and return it to our office at least 48 hours prior to your appointment. Thank you.

Patient's full name: _____ Date of Birth: _____

Address: _____ Phone number: _____

_____ Email: _____

Parent/Caregiver name(s): _____

Health Card Number: _____ Version Code: _____ Expiry: _____

Credit Card Number: _____ Expiry: _____ Security Code: _____

Name on Credit Card: _____ Billing Address: _____

Were you referred to our clinic? ☐ Yes ☐ No

If yes, whom may we thank for this referral? _____

MEDICAL HISTORY

Family Doctor: _____ Family Doctor Phone Number: _____

Allergies: _____

Medical conditions: _____

_____

Medications (incl. vitamins/supplements): _____

_____

Do any eye diseases run in the family? _____

_____

VISUAL HISTORY

Date of last eye exam: _____ Optometrist: _____

Has your child been diagnosed with an eye disease? _____

Please describe any previous eye or vision problems and treatment your child has received (including glasses, vision therapy, patching, surgery, medications, etc.): _____

_____

_____

Does your child wear glasses? ☐ Yes ☐ No ☐ N/A If yes, when? _____

At what age did your child begin wearing glasses? _____

Do you observe, or does your child report any of the following: (Please check all that apply)

☐ Headaches	☐ Double Vision	☐ Crossed or wandering eye
☐ Blurred Vision (near)	☐ Eyes hurt or tired	☐ Difficulty tracking an object
☐ Blurred Vision (far)	☐ Squinting	☐ Closes or covers one eye
☐ Tilts head	☐ Motion/car sickness	☐ Burning, itching or tearing
☐ Light sensitivity	☐ Focus goes in and out	☐ Nausea with visual tasks
☐ Difficulties with memory	☐ Loses attention easily	

MYOPIA RISK FACTORS

Please list any parents or siblings who have myopia/nearsightedness:

Family Member (i.e. dad)	Age of first pair of glasses (i.e. 9 yrs. old)	Approximate Current prescription (i.e. -7.00)

Note: If someone in the family has had laser eye surgery (LASIK or PRK) please include them in the list, and what their prescription was prior to the surgery

Any family history of connective tissue disease (i.e. Marfan Syndrome, Pseudoxanthoma elasticum, etc)?
☐ Yes ☐ No

Does your child rub his/her eyes a lot? ☐ Yes ☐ No

On average, how much time per day does your child spend outdoors?
In summer: _____ In winter: _____

Where does your child study/do their homework (i.e. desk, kitchen table, etc)? _____

Are they facing a wall, or out into an open room? _____

On average how much time per day does your child spend on electronics/screens? _____

What type of screens does your child typically use? (Please check all that apply)
☐ Computer ☐ Laptop ☐ Tablet/iPad ☐ Phone ☐ TV Other: _____

Do they keep the room lights on when on electronics? ☐ Yes ☐ No

Where are they usually when on electronics (i.e. sitting on couch, laying in bed, etc)?
_____

On average how much time per day does your child read (paper books)? _____

Do they keep the room lights on when on reading? ☐ Yes ☐ No

Where are they usually when they are reading (i.e. sitting on couch, laying in bed, etc)?
_____

Has your child tried any previous myopia control treatments? ☐ Yes ☐ No

If yes, please list:

How successful were these myopia control treatments?

EDUCATIONAL HISTORY

Current school: Grade:

Is your child receiving any tutoring, extra help or special classes? ☐ Yes ☐ No

If yes, please describe:

Has your child ever been diagnosed with a learning disability? ☐ Yes ☐ No

If yes, please describe:

How much time each day, on average, does your child spend on homework/assignments?

To what extent do you assist your child with his/her homework/assignments?

Do you feel your child is achieving up to his/her potential? ☐ Yes ☐ No

Does the teacher feel your child is achieving up to his/her potential? ☐ Yes ☐ No

Academic concerns:

- ☐ Avoids reading
- ☐ Poor, inefficient reading
- ☐ Loses place while reading
- ☐ Poor reading comprehension
- ☐ Vocalizes when reading
- ☐ Uses finger to track along line when reading
- ☐ Holds book really close
- ☐ Skips, rereads or omits words/lines
- ☐ Words moving/running together
- ☐ Confuses left and right
- ☐ Difficulty copying from the board
- ☐ Poor spelling
- ☐ Poor handwriting
- ☐ Frequent letter, number or word reversals
- ☐ Math difficulty (facts/concepts)

Current academic levels:

	Above Grade	On Grade	Below Grade	Special Help
Reading	☐	☐	☐	☐
Reading Comprehension	☐	☐	☐	☐
Spelling	☐	☐	☐	☐
Math	☐	☐	☐	☐
Handwriting	☐	☐	☐	☐

DEVELOPMENTAL HISTORY

Full-term pregnancy? ☐ Yes ☐ No If no, how premature?

Were there any complications during pregnancy and/or delivery? ☐ Yes ☐ No

If yes, please explain:

Birth weight: Apgar score @ 1 min: Apgar score @ 5 min:

When did you child begin crawling?

Was it a normal crawl? ☐ Yes ☐ No

If no, please describe the crawl (i.e. bum scoot, one legged crawl, etc.)?

When did your child begin walking unassisted?

Was your child delayed in meeting any of their developmental milestones? ☐ Yes ☐ No

If yes, please explain:

Any speech problems? ☐ Yes ☐ No Any problems with fine motor coordination? ☐ Yes ☐ No

Is your child clumsy? ☐ Yes ☐ No

Any other pertinent information?

FURTHER INFORMATION

Is there anything else you would like to tell us?

PLEASE BRING YOUR CURRENT GLASSES AND SUNGLASSES TO YOUR EXAM