EyecarePlus®
YOUR VISION – OUR FOCUS
"Aphrodite Livanes Optometrists"

Aphrodite Livanes
Optometrists

Shop 43, Alexandra Hills Shopping Centre
Cnr Finucane Road & Cambridge Drive
Alexandra Hills QLD 4161
Phone 07 3824 1878 Fax 073824 6326

Parent Pre-Examination Questionaire

This form provides initial information for a visual examination. This examination goes beyond the traditional sight examination. It investigates how efficiently your child understands what he/she sees. Optimum school performance requires optimum visual function.

IT WOULD BE GREATLY APPRECIATED IF BOTH PARENTS COULD ATTEND THE EXAMINATION

Child's Full Name .....

School ..... Grade .....

Teacher's Name .....

1. Who recommended that you consult us? .....

2. What is the reason for today's examination?.....

.....

3. Previous visual examinations? YES / NO

4. Were glasses prescribed? YES / NO

5. Have there been any academic difficulties? YES / NO

If so, please explain.....

.....

6. Does your child have a tutor? YES / NO

7. Do you feel your child needs a tutor? YES / NO

8. Were there any complications during pregnancy or birth? YES / NO

9. Is your child generally healthy? YES / NO

10. Current medication? .....

11. List any illnesses or injuries to the head or eyes.....

12. Is there any family history of eye diseases? YES / NO

13. Has your child suffered from recurrent ear infections? YES / NO

14. Does or has your child experienced poor sleep patterns? YES / NO

15. Has you child seen a speech pathologist or occupational therapist? YES / NO

Have you or anyone noted the following about your child, or has your child complained of:

- ☐ Headaches
- ☐ Head extremely tilted when doing close work
- ☐ Poor attention span on close visual tasks
- ☐ Poor eye/hand coordination
- ☐ Frequent blinking or eye rubbing
- ☐ One eye turns in or out
- ☐ Holds reading close
- ☐ Messy and poorly spaced writing
- ☐ Blurry distance vision (e.g. Board, TV)
- ☐ Blurry near vision (e.g. Reading)
- ☐ Watery eyes
- ☐ Difficulty keeping place when reading and/or copying
- ☐ Red eyes
- ☐ Squinting
- ☐ Itchy eyes
- ☐ Closes or covers one eye
- ☐ Letter, number or word reversals
- ☐ Sore Eyes

I authorize the release of this information and subsequent clinical findings to my child's school and referring practitioner.

Signature ..... Date ..... / ..... / .....