WELCOME TO
CRANDON & CRANDON OPTOMETRY

CLEAR VISION BEGINS WITH HEALTHY EYES

Questionnaire for Patients ages 16 and under

Does your Child report any of the following?

Headaches:	Yes ☐	NO ☐	If so, When? ____ _____
Blurred Vision:	Yes ☐	NO ☐	If so, When? _____
Double Vision:	Yes ☐	NO ☐	If so, When? _____
Eyes Tired:	Yes ☐	NO ☐	If so, When? _____

Have you ever noticed the following?

Frequent red eyes?	Yes ☐	NO ☐	If so, When? ____ _____
Frequent Eye Rubbing?	Yes ☐	NO ☐	If so, When? ____ _____
Frequent Blinking?	Yes ☐	NO ☐	If so, When? ____ _____
Closing/Covering One Eye?	Yes ☐	NO ☐	If so, When? ____ _____
Tilting Head when reading?	Yes ☐	NO ☐	If so, When? ____ _____
Moves Head when reading?	Yes ☐	NO ☐	If so, When? ____ _____
Confuses Letters/Words?	Yes ☐	NO ☐	If so, When? ____ _____
Reverses Letters/Words?	Yes ☐	NO ☐	If so, When? ____ _____
Skips Rereads or Omits Words?	Yes ☐	NO ☐	If so, When? ____ _____
Vocalized when reading silently?	Yes ☐	NO ☐	If so, When? ____ _____
Reads Slowly?	Yes ☐	NO ☐	If so, When? ____ _____
Uses Finger as Marker?	Yes ☐	NO ☐	If so, When? ____ _____
Poor Reading Comprehension?	Yes ☐	NO ☐	If so, When? ____ _____
Writes or Prints Poorly?	Yes ☐	NO ☐	If so, When? ____ _____
Avoids Near Tasks?	Yes ☐	NO ☐	If so, When? ____ _____
Short Attention Span?	Yes ☐	NO ☐	If so, When? ____ _____
Poor Motor Coordination?	Yes ☐	NO ☐	If so, When? ____ _____

SCHOOL HISTORY

Does your child like school? Yes ☐ NO ☐

Does your child like their teacher? Yes ☐ NO ☐

Does your child like to read? Yes ☐ NO ☐

Do you feel your child is working up to their potential? Yes ☐ NO ☐

Does teacher feel your child is working up to their potential? Yes ☐ NO ☐

What school subjects are easy for your child? _____

What school subjects are difficult for your child? _____

Has a grade been repeated? Yes ☐ NO ☐ if yes, what Grade? _____

Has your child had tutoring or remedial assistance? Yes ☐ NO ☐