PARENT QUESTIONNAIRE
OMNI EYE CENTER – LASER VISION

CHILD'S NAME _____ CHILD'S AGE _____

I. Background Information

School _____ Grade_____ Teacher _____

Was your child referred to our office by an optometrist, ophthalmologist, reading center, school teacher, or school nurse? ☐ Yes ☐ No

If so, by whom? _____

II. Visual History

Check all of the following that you have noticed in your child:

- ☐ Eyes crossed or turning in or out at any time
- ☐ Reddened or watering eyes
- ☐ Avoiding reading and close work
- ☐ Short attention span or daydreaming
- ☐ Placing head close to book when reading or writing
- ☐ Excessive blinking or tendency to rub eyes
- ☐ Restlessness after prolonged visual concentrations
- ☐ Losing place while reading
- ☐ Difficulty in remembering what has been read
- ☐ Saying words aloud while reading
- ☐ Persistent reversals after the second grade
- ☐ Confusion of similar words
- ☐ Unusual awkwardness
- ☐ Headaches
- ☐ Nausea or dizziness
- ☐ Burning or itching of the eyes
- ☐ Blurring of vision at any time

III. School History

How would you describe you child's school achievement?

_____

IV. Performance

What is your child's average grade in reading? _____ in math? _____