

**PRESCHOOL VISION QUESTIONNAIRE**  
 Avenue Vision, L.L.C. 1208 Washington Golden, CO 80401 303-279-3713

Child's Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ Parents Names: \_\_\_\_\_

Last Eye Examination:  1yr  2yrs  5yrs  Here  Elsewhere \_\_\_\_\_

Former Patients: What do you like about us? Excellence -Convenience – Friendliness –Other \_\_\_\_\_

New Patients: How did you hear of us? Sign Newspaper Yellow Pages Insurance Friend \_\_\_\_\_

Health: Excellent Good Fair What % of waking hours does your child wear xGlasses \_\_\_\_\_ xContacts \_\_\_\_\_

Main reason for this visit? Health Test – New Glasses – Vision Problem \_\_\_\_\_

Medications (including over the counter drugs, supplements) \_\_\_\_\_

**Has anyone in the family had the following conditions? F = Family P = Patient .**

- |  |   |  |  |  |
|--|---|--|--|--|
| <input type="checkbox"/> F <input type="checkbox"/> P Asthma | <input type="checkbox"/> F <input type="checkbox"/> P Allergies | <input type="checkbox"/> F <input type="checkbox"/> P Color Vision Defects | <input type="checkbox"/> F <input type="checkbox"/> P Eye Turn | <input type="checkbox"/> F <input type="checkbox"/> P Lazy Eye |
| <input type="checkbox"/> Diabetis                            | <input type="checkbox"/> Sinus Prob                             | <input type="checkbox"/> Frequent Ear Infection                            | <input type="checkbox"/> Mumps                                 | <input type="checkbox"/> Measles                               |
| <input type="checkbox"/> Chicken Pox                         | <input type="checkbox"/> Tuberculosis                           | <input type="checkbox"/> High Blood Pressure                               | <input type="checkbox"/> Head Injury                           | <input type="checkbox"/> Eye Injury                            |
| <input type="checkbox"/> Eye Infection                       | <input type="checkbox"/> Eye Surgery                            |  |  |  |

**B I R T H Y = Yes N = No E X P L A I N A T I O N .**

- Y  N Normal Pregnancy \_\_\_\_\_
- Y  N Normal Delivery \_\_\_\_\_
- Y  N Mother <35 yrs old \_\_\_\_\_
- Y  N Fetal Distress \_\_\_\_\_
- Y  N Apgar above 6 \_\_\_\_\_
- Y  N Mom a smoker \_\_\_\_\_

**D E V E L O P M E N T N = Normal A = Abnormal A C T I V I T I E S S/He enjoys!**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> N <input type="checkbox"/> A Lifting neck and head | <input type="checkbox"/> N <input type="checkbox"/> A Walking        | <input type="checkbox"/> Blocks & Puzzles | <input type="checkbox"/> Tricycle/Bicycle   |
| <input type="checkbox"/> N <input type="checkbox"/> A Rolling over          | <input type="checkbox"/> N <input type="checkbox"/> A Talking        | <input type="checkbox"/> Dolls/ Animals   | <input type="checkbox"/> Books              |
| <input type="checkbox"/> N <input type="checkbox"/> A Sitting Up            | <input type="checkbox"/> N <input type="checkbox"/> A Catching Balls | <input type="checkbox"/> Trucks/Cars      | <input type="checkbox"/> Screen Time        |
| <input type="checkbox"/> N <input type="checkbox"/> A Crawling              | <input type="checkbox"/> N <input type="checkbox"/> A Colors         | <input type="checkbox"/> Jumping, Hopping | <input type="checkbox"/> Climbing           |
| <input type="checkbox"/> N <input type="checkbox"/> A Hand Dominance        |  | <input type="checkbox"/> Running          | <input type="checkbox"/> Ball Sports        |
|   |  | <input type="checkbox"/> Digging          | <input type="checkbox"/> Gymnastics, Ballet |

Other \_\_\_\_\_

**P R O D U C T S These eyewear options are of interest at this time. .**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Light Weight Lenses | <input type="checkbox"/> Flexible Frames   | <input type="checkbox"/> Ultra-Violet Blocker | <input type="checkbox"/> Tint that Changes Color |
| <input type="checkbox"/> Quick Service       | <input type="checkbox"/> Ultra Thin Lenses | <input type="checkbox"/> Shatterproof Lenses  | <input type="checkbox"/> Glare Reduction Coating |
| <input type="checkbox"/> No-Line Bifocals    | <input type="checkbox"/> Back-up Glasses   |   |  |

**S E R V I C E S .**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Vision Therapy for Academics | <input type="checkbox"/> Vision Enhancement for Sports | <input type="checkbox"/> Preventive Therapy |
| <input type="checkbox"/> Nutrition for Better Vision  |  |   |