Ocular History (Child):

Parent/Caregiver's Questionnaire

Child's Name: _____

Date: _____

Child's Age: _____

Parents/Caregivers: Please complete the questions below to the best of your knowledge by circling yes or no. Where possible provide comments or examples of behaviors discussed.

1. **Does the child have prescription glasses or contacts?**

   YES NO Comment:_____

2. **If yes, did the child bring the glasses with today?**

   YES NO Comment:_____

3. **Is there anyone in the child's family who has had amblyopia (lazy eye) or any other vision problem that was not caused by an injury to the eye?**

   YES NO Comment:_____

4. **Does your child hold objects close to his/her face when trying to see them?**

   YES NO Comment:_____

5. **Do your child's eyes ever seem to cross or drift?**

   YES NO Comment:_____

6. **Do your child's eyes appear unusual in any way?**

   YES NO Comment:_____

7. **Do your child's eyelids droop or does one eyelid tend to close?**

   YES NO Comment:_____

8. **Have your child's eye(s) ever been injured?**

   YES NO Comment:_____

9. **Does your child do any of the following actions:**

Rubs eyes constantly	YES	NO
Regularly closes or covers one eye when looking at objects	YES	NO
Squints eyes or frowns when looking at objects near or far	YES	NO
Reports feeling dizzy or nauseous after doing close up work	YES	NO