



INNER WEST EYE CARE

New Patient Questionnaire — Child

Thank you for taking the time to complete this form. It helps us understand your child before their visit, and everything you share stays confidential.

CHILD & FAMILY DETAILS

Child's name	Date of birth dd / mm / yyyy	Age yrs / mths
Home address		
Parent/guardian email		Phone
School	Grade / Year	
Who referred you to us? e.g. GP, school, friend		
Main reason for today's visit		

DEVELOPMENTAL HISTORY

Birth weight	Birth order (e.g. first, second, twin)
Type of delivery: ☐ Natural ☐ Caesarean ☐ Forceps	
Child was born premature or required special care after birth ☐ Yes ☐ No	
First words spoken <u> mths </u> First crawled <u> mths </u> First walked <u> mths </u>	
Child's coordination seems as expected for their age ☐ Yes ☐ No	
Preferred hand: ☐ Right ☐ Left ☐ Either / not yet clear	
Anything else about your child's development?	

GENERAL & MEDICAL HEALTH HISTORY

Serious illness, injury or hospitalisation? Detail	Previous head or eye injury? Detail
History of any of the following? (tick all that apply)	
☐ ADD / ADHD	☐ Ear infections
☐ High fevers	☐ Asthma
☐ Other	☐ Tonsillitis
☐ Other	☐ Chronic headaches
Current medications	Allergies (food, medication, environment)
Family history of: (tick all that apply)	
☐ Eye turn	☐ Lazy eye
☐ AMD	☐ Other
☐ High prescription glasses	☐ Glaucoma
Does child live with both parents? ☐ Yes ☐ No	
Has child seen or had: (tick all that apply)	
☐ Speech therapy	☐ Occupational therapy
☐ Paediatrician	☐ Educational psychologist
Anything else about your child's health?	

VISUAL HISTORY

Previous visual assessment? ☐ Yes ☐ No	Approx. date
Glasses ever prescribed? ☐ Yes ☐ No	One eye ever patched? ☐ Yes ☐ No
Eye turns in or out? ☐ Yes ☐ No	Sensitive to / screws up eyes in bright light? ☐ Yes ☐ No
Anything else about your child's vision?	

EDUCATIONAL HISTORY

Enjoys school? ☐ Yes ☐ No

Repeated a grade? ☐ Yes ☐ No

Tutoring / remedial support?

School performance, if known

Below average

Average

Above average

Reading ☐ ☐ ☐

Writing ☐ ☐ ☐

Spelling ☐ ☐ ☐

Maths ☐ ☐ ☐

Any other comments regarding your child's education?

SIGNS & SYMPTOMS CHECKLIST

For each item, mark how often it happens for your child.

	Never	Sometimes	Often	Usually
Crossed eyes / turning in or out	☐	☐	☐	☐
Headaches (particularly at the end of the day)	☐	☐	☐	☐
Difficulty seeing clearly at distance	☐	☐	☐	☐
Blurry or fuzzy vision when reading, writing or using a screen	☐	☐	☐	☐
Print goes double or words 'swim' or run into each other when reading	☐	☐	☐	☐
Eyes burn, itch or become sore during or after close work	☐	☐	☐	☐
Sensitive to glare	☐	☐	☐	☐
Loses place or skips lines when reading	☐	☐	☐	☐
Holds book or screen/device very close	☐	☐	☐	☐
Rubs eyes when reading	☐	☐	☐	☐
Uses finger to keep place	☐	☐	☐	☐
Tilts head or covers one eye when reading	☐	☐	☐	☐
Untidy or slow writing	☐	☐	☐	☐
Reverses letters or numbers	☐	☐	☐	☐
Trouble learning right and left	☐	☐	☐	☐
Mistakes words with similar beginnings	☐	☐	☐	☐
Doesn't recognise the same word repeated on a page	☐	☐	☐	☐
Trouble with spelling and sight word vocabulary	☐	☐	☐	☐
Knows material but does poorly on written tests	☐	☐	☐	☐
Good verbal but poor reading comprehension	☐	☐	☐	☐
Trouble learning size / magnitude concepts in maths	☐	☐	☐	☐
Slow copying from board to book	☐	☐	☐	☐

Any other signs/symptoms of vision problems?

Anything else you think would be important for us to know about your child?

Thank you. Looking forward to helping your child reach their visual potential!