

9WWRWK2SWEDQ

~~DR~~ ~~GHYH~~ ~~GD~~ ~~Q~~ ~~HWHWD~~ ~~WWK2SWEDQ~~ ~~SWRPHW~~ ~~W~~"

HV

~~Q~~

~~W~~

Which Optician / Optometrist?

Date of last check:

Date of next check:

Was your child prescribed glasses?

yes

no

don't know



Visits to the Hospital

Has your child ever been to see the eye clinic in a hospital?

yes

~~Q~~

~~W~~



~~Q~~

~~W~~



~~Q~~

~~W~~



~~Q~~

~~W~~

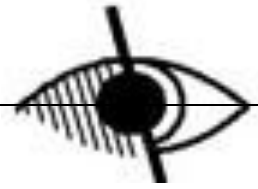


~~Q~~

~~W~~

Is your child registered blind / severely sight impaired?

yes no don't know



Is your child registered partially blind / sight impaired?

yes no don't know

Is your child using their glasses now?

yes no don't know

Does your child have any problems with their glasses?

yes no don't know

Comments:

Do you have any concerns about your child's eyes?

yes no don't know



If yes, please write what the problems are:

Is there a history of blastoma in your family?

yes no don't know

Other useful information

Has anyone in your family had eye problems?

yes no don't know



For example has anyone needed to wear glasses as a child, had a squint / strabismus, patching one eye or an eye condition or blastoma?

If yes, please write who has had problems and what problems they've had:

Who	What problem

Do your child's eyes always appear straight?

yes no don't know

If one/both eyes appear to wander, which eye does this and how often?
Do your child's eyes ever appear to move excessively rapidly or uncontrollably?
Do you think your child has trouble controlling his/her eye movements?

If so please give details if possible:

Does your child complain of headaches?

yes no don't know

Does your child tend to shut one eye?

yes no don't know

Does your child appear very sensitive to bright lights?

yes no don't know

More about your child

Does your child use a wheelchair?

yes no sometimes



Does your child have any health problems or disabilities?

yes no sometimes



If yes, please say what they are:

Birth history

Please give details of any difficulties/problems with your pregnancy or child's birth.
(i.e: mother having infection, prematurity, low birth weight, need for special care etc)

Does your child take any medication?

yes no don't know



If yes, please take information about your child's medication with you to the eye test and list them below:

Does your child have any allergies?

yes no don't know

If yes, please list them below:

Is your child deaf or hard of hearing?

yes no



If yes, please tell the optometrist about your child's hearing:

Does your child find it hard to communicate?

yes no sometimes

What helps your child to communicate? Tell us if you use things like:

Makaton  yes no

Other (please describe how you communicate with your child):

An interpreter yes no

Pictures  yes no

Gestures yes no

About your child's eyes



When your child has their eye test the optometrist will need to look at their eyes.

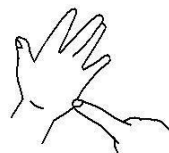
They will also do some tests to check how well they can see.

The information you give the optometrist will help them to test your child's eyes.

Can your child say or sign the names of letters on any eye test chart?



← T →

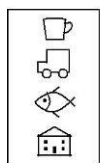


yes

no

don't know ?

Can your child say or sign the names of pictures on a chart like **house**, **fish** or **car**?



← House →

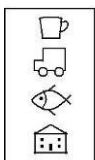


yes

no

don't know ?

Can your child point to a letter or picture on a card that is the same as a letter or picture on a chart on the wall?



yes

no

don't know ?

Will your child be able to wear test frames on their face?

yes

no

don't know ?



Will your child be okay if the optometrist were to cover their eyes one at a time?

yes no don't know ?



Can your child understand 'better' and 'worse'?

yes no don't know ?



better



worse

Will your child be okay if the optometrist comes close to them and shines a bright light in their eye?

yes no don't know ?



Will your child be okay if the optometrist puts drops in their eyes?

Some eye drops may sting for a bit, or make it hard to see for a short time. You can ask the optometrist about this.

yes no don't know ?



Five key questions

We would also like you to consider the following five questions. These questions are designed for a range of ages and abilities, so some questions may not be relevant. Your child may have difficulty with some behaviours listed below but not others – this is normal. You may also notice that some of the behaviours described occur only occasionally or more frequently when your child is tired, this is common.

Tick the box which best describes your child's current behaviour and if for example your child uses a wheelchair and the stairs question is not relevant, ring "not applicable".

1. Does your child have difficulty walking downstairs?

Never	Rarely	Sometimes	Often	Always	Not applicable
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2. Does your child have difficulty seeing fast-moving objects?

Never	Rarely	Sometimes	Often	Always	Not applicable
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3. Does your child have difficulty seeing something that is pointed out in the distance?

Never	Rarely	Sometimes	Often	Always	Not applicable
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4. Does your child have difficulty locating an item of clothing in a pile of clothes?

Never	Rarely	Sometimes	Often	Always	Not applicable
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5. Does your child find copying words or pictures time-consuming and difficult?

Never	Rarely	Sometimes	Often	Always	Not applicable
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Please tell us any other information we may need to know:


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