Please save the form on your computer before filling it out.

# Welcome!

sehzentrum RAPPERSWIL
Spezialisten für Ihre Augen
Rapperswil Zürich

## Personal information

☐ Mr. ☐ Ms. ☐

| | | | |
|---|---|---|---|
| **Family name:** | | **Given name:** | |
| **Street:** | | **Zip code/city:** | |
| **Date of birth:** | | **Tel home:** | |
| **E-mail:** | | **Mobile:** | |
| **Sport/hobby:** | | **Profession:** | |

## Referred / Recommended by:

## Main reason for an optometric check-up at sehzentrum rapperswil:

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## Are you undergoing medical treatment?

☐ ophthalmologist ☐ paediatrician ☐ osteopathy ☐ homeopathy ☐ other

## I wear:

☐ glasses ☐ contact lenses

## My last check-up with an eye doctor:

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**I hereby consent to the following terms and conditions:***

☐ Yes ☐ No **Date:** **Signature:**

***Terms and conditions:**

- Please change or cancel apointments 24 hours in advance. Cancelations on short notice will be charged according to the time reserverd.
- If relevant, check with your health insurance provider to what extent costs are covered.
- I consent to the sehzentrum rapperswil, if needed, to pass my relevant examination results to my doctors or therapists for the purpose of completing my patient dossier.
- I hereby accept the date protection policy as under https://www.sehzentrum-zuerich.ch/datenschutz.html

# Questionnaire for first examination of children or juniors

sehzentrum RAPPERSWIL

Dear parents and guardians:
We kindly ask you to fill out the below checklist as fully as possible to help us to have the best overall understanding of visual situation of your child. We will afterwards be here to help if you have any questions. Thank you very much!

**Name of child:** **Date of birth:** **Date:**

| | No | Yes | | |
|---|---|---|---|---|
| Have the eyes of your child ever been checked before? | ☐ | ☐ | By whom? | |
| If yes, what was the result? | | | | |
| Have glasses ever been prescribed? | ☐ | ☐ | When was the first time? | |
| Has your child had any form of therapy? | ☐ | ☐ | Which one? | |
| Has your child ever been to an orthodontist? | ☐ | ☐ | | |
| Does your child have any allergies? | ☐ | ☐ | Which one? | |
| Is your child taking any medication? (incl. Ritalin etc.)? | ☐ | ☐ | Which one? | |

| **Have the following ever been observed?** | No | Yes | Sometimes | Unknown |
|---|---|---|---|---|
| A short distance for colouring / reading / writing | ☐ | ☐ | ☐ | ☐ |
| Follows the words with their finger while reading | ☐ | ☐ | ☐ | ☐ |
| Omits letters or endings when reading | ☐ | ☐ | ☐ | ☐ |
| Mixes up letters like d+b, p+q etc.. | ☐ | ☐ | ☐ | ☐ |
| Happens to skip lines when reading | ☐ | ☐ | ☐ | ☐ |
| Does not like reading, prefers comics | ☐ | ☐ | ☐ | ☐ |
| Has difficulties to see the board clearly | ☐ | ☐ | ☐ | ☐ |
| Words are blurred, as if through tears, shaky, letters dance | ☐ | ☐ | ☐ | ☐ |
| Writes above or below the line, not straight | ☐ | ☐ | ☐ | ☐ |
| Anxious or unsure of catching a ball, too late / too early | ☐ | ☐ | ☐ | ☐ |
| Eyes tire easily, mostly when reading | ☐ | ☐ | ☐ | ☐ |
| Often rubs the eyes, has red eyes | ☐ | ☐ | ☐ | ☐ |
| Rolls or turns the eyes | ☐ | ☐ | ☐ | ☐ |
| Relatively sensitive – even in standard indoor lighting | ☐ | ☐ | ☐ | ☐ |
| Suffers from pain (pressure / pull) near the eye or eyesocket | ☐ | ☐ | ☐ | ☐ |
| Suffers from headaches / migraines? | ☐ | ☐ | ☐ | ☐ |
| One eye shifts to: ☐ the right ☐ the left | ☐ | ☐ | ☐ | ☐ |
| Catches corners, stumbles or tips things over | ☐ | ☐ | ☐ | ☐ |
| Finds it difficult to fall asleep | ☐ | ☐ | ☐ | ☐ |

Send