

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

# Welcome!

## 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 zürich:

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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 appointments 24 hours in advance. Cancellations on short notice will be charged according to the time reserved.
- If relevant, check with your health insurance provider to what extent costs are covered.
- I consent to the sehzentrum zürich, 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 data protection policy as under <https://www.sehzentrum-zuerich.ch/datenschutz.html>

# Questionnaire for first examination of children or juniors

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