

## Pre-Consult Questionnaire

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Grade in School: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Best Contact Email: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### Current Vision & Eye History

Has your child had a recent eye exam?

- Yes (within last 12 months)  Yes (over 12 months ago)  No

Does your child currently wear:

- Glasses  Contact Lenses  Both  Neither

If yes, when was their prescription last updated?

- Within last 6 months  1 year ago  2 years ago  Longer than 2 years

Have you noticed any recent changes?

- Squinting  Moving closer to screens/books  
 Headaches  Complaints of blurry distance vision  
 Eye strain  Failed school screening or DMV exam  
 None  Other: \_\_\_\_\_

Has your child's prescription increased in the past?

- Yes (rapidly)  Yes (slowly)  
 No  Unsure

### Family History

Do either parents have nearsightedness (myopia)?

- Yes – one parent  Yes – both parents  
 No  Unsure

If yes, how strong is/was the prescription for the parent (approximate)?

- 1.00 to -3.00  
 -3.00 to -5.00  
 -5.00 to -7.00  
 Greater than -7.00  
 Unsure

### **Lifestyle & Visual Habits**

On a typical weekday, how many hours does your child spend on:

Near work (reading, homework): \_\_\_ hours/day

Screen time (tablet, phone, computer): \_\_\_ hours/day

Outdoor time: \_\_\_ hours/day

Weekend outdoor time:

Less than 1 hour/day

1–2 hours/day

2+ hours/day

Does your child take breaks during near work?

Yes (regularly)

Sometimes

Rarely

### **General Eye Health**

Any history of:

Eye disease

Lazy eye (amblyopia)

Eye injury

Eye turn (strabismus)

Eye surgery

None

Any medical conditions or medications we should be aware of?

### **Readiness & Preferences**

Has your child ever worn contact lenses?

Yes

No

Tried but stopped

How comfortable would your child be with contact lenses?

Very comfortable

Somewhat comfortable

Nervous

Not open to it

What are your goals for this consultation? (check all that apply)

Slow or stop worsening vision

Reduce future eye health risks

Learn about treatment options

Avoid strong prescriptions

Other: \_\_\_\_\_

What concerns do you have about myopia management?

Safety

Effectiveness

Cost

Child cooperation

Time commitment

Other: \_\_\_\_\_

**Commitment & Expectations**

Myopia management typically requires: Ongoing follow-up visits + Daily treatment + Lifestyle changes  
How ready are you to commit to this?

- Very ready
- Somewhat ready
- Unsure

Preferred treatment types you are interested in (if known):

- Eye drops (e.g., atropine)
- Soft multifocal contact lenses
- Myopia glasses
- Not sure / want guidance

What would make this program feel like a success for your child/family?

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**Referring Provider**

Doctor Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Fax: \_\_\_\_\_

\*After completion of this **Pre-Consult Questionnaire**, Dr. Graff’s team will reach out to schedule the **Virtual Consult**. Consults are scheduled on Wednesday mornings and last 20 minutes.

\*After the Virtual Consult is scheduled you will receive a confirmation email with an invite for parents/ guardians to join this meeting via video chat or phone call for the designated time.

\* This appointment allows parents / guardians to ask questions, verify expectations and share critical data before enrolling in the Myopia Management program.