



**ROK Group**  
School of Optometry and Vision Science  
University of New South Wales  
Sydney NSW 2052

email: [ROKInfo@unsw.edu.au](mailto:ROKInfo@unsw.edu.au)

Fax: 9313 6243 or **Post it to the above address.**

## Questionnaire:

**Name of Child:** (Mast., Miss) \_\_\_\_\_  
(first name) (surname)

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ years

**Name of Parents/Guardian** \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_

☎ business hrs: \_\_\_\_\_ ☎ after hrs: \_\_\_\_\_

📞 mobile: \_\_\_\_\_ (Please indicate  your preferred contact number)

✉ email: \_\_\_\_\_

**Please tick  the appropriate box (tick more than one box if necessary):**

1a. Which of the following does your child wear for the correction of their eyesight?

- Spectacles
- Contact lenses
- Both
- None

**Please supply a copy of their most recent prescription (if available).**

Right Eye \_\_\_\_\_ Left Eye \_\_\_\_\_

**How long ago was your child's most recent eye examination?** \_\_\_\_\_

1b. Does your child wear these for:

- Myopia (short sightedness)
- Hypermetropia (long sightedness)
- Astigmatism
- not sure

1c. How long has your child been wearing the following?

- Spectacles.....yrs  
Frequency (*circle one*): constantly / occasionally / rarely
- Contact lenses.....yrs  
Frequency (*circle one*): constantly / occasionally / rarely

2. Has your child ever worn hard (rigid gas permeable or RGP) contact lenses?

- Yes
- No

3. Does your child suffer (or have they suffered) from any of the following eye conditions?

- No
- Yes (*tick  more than one of the following boxes if applicable*):
  - Keratoconus
  - Corneal dystrophies
  - Allergic/infectious conjunctivitis
  - Corneal infections
  - Previous eye surgery or trauma (please specify \_\_\_\_\_ )
  - Eye lid infections
  - Dry eyes
  - Other (please specify \_\_\_\_\_ )

4. Does your child suffer from any of the following health conditions?

- No
- Yes (*tick  more than one of the following boxes if applicable*):
  - Allergies (describe \_\_\_\_\_ )
  - Diabetes
  - Sjögren's syndrome
  - Thyroid problems
  - Other (describe \_\_\_\_\_ )

5. What is the ethnicity of your child?

- |                          |                                     |                               |  |
|--------------------------|-------------------------------------|-------------------------------|--|
| Father                   | <input checked="" type="checkbox"/> | Mother                        |  |
| <input type="checkbox"/> | <input type="checkbox"/>            | Mainland/Hong Kong Chinese    |  |
| <input type="checkbox"/> | <input type="checkbox"/>            | Singaporean                   |  |
| <input type="checkbox"/> | <input type="checkbox"/>            | Taiwanese                     |  |
| <input type="checkbox"/> | <input type="checkbox"/>            | Korean                        |  |
| <input type="checkbox"/> | <input type="checkbox"/>            | Japanese                      |  |
| <input type="checkbox"/> | <input type="checkbox"/>            | Other (please specify _____ ) |  |

Although our research will be conducted by fully qualified optometrists, we do not intend to replace the service provided by your child's optometrist/ophthalmologist. Therefore, we encourage you to maintain your child's schedule of regular eye check-ups with their local/regular optometrist/ophthalmologist.

6. (Optional) Please provide contact details of your child's current optometrist/ophthalmologist:

If your child is accepted into our studies, we would like to contact their current optometrist/ophthalmologist to advise them of their participation, and to provide updates of their progress in orthokeratology lens wear.

Optometrist/Ophthalmologist name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Thank you for your assistance.