

University of Houston NEAR Survey

Child's age:

Child's Date of birth:

How many siblings does the child have?

Is your child Sephardic or Ashkenazi or other? select all that apply

Name of City where your child lives

Name of Street where your child lives

Was your child born in Israel? _____yes _____no

If not, what country were they born?

How old was your child when he/she moved to Israel?

Select the type of school your child attends:

- Religious public School
- Secular Public School
- Ultra-Orthodox School
- Other

How many hours a day (Sunday-Thursday) is your child at school on average?

Does your child study on Friday?

If so, how many hours is your child at school on Friday?

If your child is at an ultra-Orthodox school, please state when he/she is on vacation.

At what age was your child taught to read in school?

What are your child's average grades in school (circle)?

- 50-60
- 61-70
- 71-80
- 81-90
- 91-100

Does your child wear glasses or contact lenses? _____yes _____no

If yes, at what age did your child first get glasses or contacts? ____

If yes, is the correction for:

- distance (i.e. nearsighted)
- near (i.e. farsighted)
- both distance and near
- unsure

Is your child's prescription getting worse each year? _____yes _____no _____unsure

- Has your child undergone the following ocular procedures?
- LASIK/laser refractive correction
- myopia control contact lenses (orthokeratology or multifocal)
- unsure
- none

Does the child's biological mother wear glasses or contact lenses? _____yes _____no _____unsure

If yes, is the correction for seeing: _____ distance _____near _____both

Age when mother started wearing glasses or contacts: _____ years old

Does the child's biological father wear glasses or contact lenses? _____yes _____no _____unsure

If yes, is the correction for seeing: _____ distance _____ near _____ both

Age when father started wearing glasses or contacts: _____ years old

Please mark the number of hours per day your child spends involved in these activities DURING THE SCHOOL YEAR when they are NOT at school.

[illegible]

7. Viewing a handheld electronic device (smart phone, tablet, handheld video games, kindle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Reading printed material (Praying, books, homework, newspaper, magazines,)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Drawing, painting, or writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Playing card or board games (not electronic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. How many hours of sleep does your child get on a week night? _____ weekend night? _____

Please mark the number of hours per day your child spends involved in these activities DURING THE SUMMER. Include time spent at camp or other activities.

[illegible]

11. How many hours of sleep does your child get on a week night? _____ weekend night? _____
