

Dear Parents:

Your child's vision develops along with such other functions as walking and talking and is affected by family history as well as by certain illnesses. Therefore, your thorough answers to this form will help in determining how your child's vision has developed as well as allowing us to use the office time for the complete optometric examination.

Child's Full Name _____ Nickname _____
 Address _____ City _____ State _____ Zip _____
 Home Telephone # _____ Parent Work # _____ Parent Cell # _____
 Email Address _____ Birthday _____ Age _____
 Grade _____ School _____ Teacher _____
 Parent's Names _____ Occupations _____
 Other Family Members at home (include ages and relationships) _____

 Insurance Carrier _____ Referred by _____

Present Situation:

Does your child seem to have any visual difficulty? _____

If yes, in what way? _____

How long has difficulty been noted? _____

Does your child ever report or appear to experience any of the following? If so, when?

headaches _____

blurred vision _____

double vision _____

eyes hurt or tired _____

Have you or anyone else ever noted the following? If so, when?

closes or covers one eye _____ has difficulty making eye contact _____

frowns, squints, or widens eyes _____ appears unfocused _____

eyes frequently reddened _____ stares at certain objects, patterns _____

eyes water or tear _____ flaps hands _____

rubs or pushes on eyes excessively _____ looks through hands _____

turns or tilts head often _____ flicks or spins objects in front of face _____

bumps into objects _____ seems confused at a change in flooring _____

gets lost in books _____ obsession with spinning _____

bothered by light _____ fascinated by light, shadows _____

eye(s) turn in or out _____ afraid of heights _____

moves head when reading _____ shows no fear of heights _____

holds reading close _____ sights along linear objects _____

uses finger when reading _____ flicks fingers by sides of face _____

reverses words or numbers _____ toe walks _____

skips words or loses place _____ has disturbances in gait _____

poor reading comprehension _____ has inconsistencies in balance _____

makes errors in copying _____ tends to feel his way along walls _____

tires easily _____ experiences car sickness or nausea _____

avoids near tasks _____ frequent frustration with near work _____

has difficulty sustaining attention to tasks _____ distractable or inattentive _____

reads slowly _____ has no interest in books or obsessed them _____

poor handwriting _____ is unable to write _____

confuses right and left _____ has difficulty organizing tasks/ activities _____

School:

Age at time of entrance to Preschool _____ Kindergarten _____ First grade _____
Is your child in a regular school program? _____ If not, please describe? _____
Does your child like school? Yes ___ No ___ Teacher Yes ___ No ___ Has a grade been repeated?
Yes ___ No ___ Has there been any school difficulty? Yes ___ No ___ Explain _____
Do you feel the child is working up to potential? _____
Is school work average _____ better than average _____ below _____
Is there any subject(s) which seem easy _____ difficult for the child? _____
How does your child learn most effectively? _____ least effectively? _____
Does your child seem to be under tension or extreme pressure when doing schoolwork? _____
Does your child like to read? _____ Voluntarily? _____ What is your child's reading level? _____

Developmental History:

Full term pregnancy? _____ Normal birth? _____ Weight _____ Any complications before, during, or immediately following delivery? _____
Did your child crawl? _____ On all fours? _____ At what age? _____
At what age did child walk? _____ Which hand does child use for eating? ___ writing? ___ throwing? ___
Which foot does child use for kicking? _____
Was child active? _____ Did or do you have any concerns regarding gross or fine motor ability? If yes, please describe _____
Did or do you have any concerns regarding your child's social or cognitive development? _____
At what age did your child speak his first words? _____ sentences? _____ Was speech clear to others? _____
Is language appropriate? _____ If not, please describe _____
Did your child begin to develop language and later show regression? _____ If yes, please describe _____

General Health:

Please list past illnesses and injuries including ear infections (indicate at what age and how severe):

Health at present? Good _____ Fair _____ Poor _____
Most recent medical examination? _____ Is your child receiving medication now? _____ If yes, please list the medications and purpose for each _____
Does your child presently suffer from any allergies or sensitivities? _____ If so, what is the treatment? _____

Has a neurological or psychological analysis been performed? _____ Results? _____
If so, does anyone in the family have learning difficulties, cognitive or psychological problems? _____
Please list any other therapies your child is receiving and indicate hours per week
Speech _____ Occupational _____ Physical _____
Nutritional _____ Chiropractic _____ Behavioral _____ Other _____

Visual History:

Have child's eyes ever been crossed or turned out? _____ When? _____
Was surgery or therapy performed? _____
Previous visual examination? _____ When? _____ Results _____
Please list members of the family who have had visual attention and why? _____

General Behavior:

Does your child actively participate in play, sports or athletics? _____
Activities child enjoys most _____
Are there any behavior problems? _____ eating problems? _____ sleep problems? _____
Does child say or do things impulsively? _____
Please give a brief description of child's personality _____