Name____ Date___________________________

Date of child's last eye examination______________ Has child ever had vision therapy? ❑ Yes ❑ No

Has Child ever worn glasses? ❑ Yes ❑ No Does he/she wear glasses now? ❑ Yes ❑ No

If yes: ❑ for distance only ❑ for near only ❑ wears them full time

Does child wear contact lenses? ❑ Yes ❑No Any problems?_____________________________

This is your opportunity to tell us about all areas of concern about your child's vision.

What is your main reason for coming here today?_________________________________

____

Have you noticed any unusual signs or symptoms that concern you?______________

____

Has your child's ability to do any activity been restricted because of vision?

Please explain____

HEALTH HISTORY: Check any conditions that apply to your child or that run in your family.

Condition	Child	Family	Condition	Child	Family
Allergies	❑ Child	❑ Family	Lazy eye	❑ Child	❑ Family
Respiratory disease	❑ Child	❑ Family	Turned eye	❑ Child	❑ Family
Cancer	❑ Child	❑ Family	Color "blind"	❑ Child	❑ Family
Diabetes	❑ Child	❑ Family	Light sensitive	❑ Child	❑ Family
Drug sensitive	❑ Child	❑ Family	Eyestrain	❑ Child	❑ Family
Heart problem	❑ Child	❑ Family	Dry eyes	❑ Child	❑ Family
High blood pressure	❑ Child	❑ Family	Floaters/spots	❑ Child	❑ Family
Thyroid	❑ Child	❑ Family	Flashing lights	❑ Child	❑ Family
Migraine or headaches	❑ Child	❑ Family	Retinal detachment	❑ Child	❑ Family
Blindness	❑ Child	❑ Family	Cataracts	❑ Child	❑ Family
Head trauma	❑ Child		Glaucoma	❑ Child	❑ Family
			Eye surgery or injury	________________	

Is your child currently under a physician's care? ❑ Yes ❑ No Why?________________________

Is your child regularly taking pills or medications? ❑ Yes ❑ No Specify ______________________

Date of child's last physical______________ How is child's general health?________________________

Developmental Milestones

Full Term Pregnancy? ❑ Yes ❑ No Normal Birth? ❑ Yes ❑ No

Any complications before, during or immediately following delivery? ❑ Yes ❑ No

Please describe____

Did your child creep (stomach on floor)? ❑ Yes ❑ No at what age?______

Did your child crawl (stomach off floor)? ❑ Yes ❑ No at what age?______

Did your child move around on all fours? ❑ Yes ❑ No at what age?______

At what age did your child walk? ______ Was your child active? ❑ Yes ❑ No

Speech: First words at age______ Was early speech clear to others? ❑ Yes ❑ No

Is child's speech clear now? ❑ Yes ❑ No

Please fill in both sides of this form as completely as possible

School-Related Vision Problems: Questions for parents:

Have any of your children had difficulty in school? ❑ **Yes** ❑ **No**

Please explain____

How do you feel your child is doing in school? ❑ **Well** ❑ **Below potential** ❑ **Poorly**

Please check the signs and symptoms that best describe how your child is doing in school

- ❑ Does your child squint when looking up from reading?
- ❑ Have trouble seeing the chalkboard?
- ❑ Frequently blink or rub eyes?
- ❑ Have headaches after doing school work?
- ❑ Frequently awkward, bump into things, knock things over?
- ❑ Hold books extremely close?
- ❑ Read a great deal of the time?
- ❑ Report that things look blurry?
- ❑ Have trouble copying work from the chalkboard to paper?

- ❑ Spend a long time doing homework that should take only a few minutes?
- ❑ Reduced attention span, can concentrate for only a moderate time?
- ❑ Covers one eye by leaning on hand?
- ❑ Lays head on desk when doing pencil work?
- ❑ Frequently loses place when reading?
- ❑ Skips or re-reads words and lines?
- ❑ Reverses words or letters (was for saw, b for d) beyond second grade?
- ❑ Does better at math than English, history or social studies?
- ❑ Must re-read material several times to grasp its meaning?
- ❑ Gets tired quickly when doing reading or homework?

- ❑ Short attention span? Can concentrate on reading work for only a few minutes.
- ❑ Daydreams a lot? Stares off into the distance frequently?
- ❑ Learns best through auditory tactics (listens to learn)?
- ❑ Misbehavior has become a problem (to cover up poor school performance)?
  - ❑ Acts up when asked to do school work
  - ❑ Class clown, "goofs off"
  - ❑ Moody or depressed about school and life
  - ❑ Aggressive, hits or dominates other children
- ❑ Avoids work that includes reading or near seeing?
- ❑ Is more than 1 year behind group in reading-related skills?
- ❑ Has poor posture? Slouches, slumps in chair?

How does your child react to fatigue? ❑ Sags ❑ Becomes Irritable ❑ Becomes Excited

Other Reaction____

How does your child react to tension? ❑ Thumb Sucking ❑ Nail Biting

Other Reaction____

RECREATION AND LEISURE: In what recreational activities does your child participate? (Circle)
Read, baseball, basketball, soccer, swim, build models, sew, dance, perform, play an instrument.

Other recreational or sports activities?__________________________________

Does your child wear protective eyewear for his/her sport? ❑**Yes** ❑**No**

Does your child watch much television? ❑ **Yes** ❑ **No** Number of hours daily__________

Does your child use a computer at home? ❑ **Yes** ❑ **No** Number of hours daily__________

Does your child use a computer at school? ❑ **Yes** ❑ **No** Number of hours daily__________

Does child often play video games? ❑ **Yes** ❑ **No** Number of hours daily__________

Does he/she play hand-held video games? ❑ **Yes** ❑ **No** Screen type ❑ Bright ❑ Dim

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