Child's Name: _____ **D.O.B:**_____ **Patient #:**_____

The information in this personal history form is critical to the evaluation of your child's vision.

****Please tell us about any areas of concern you have concerning 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 limited or restricted because of vision? ○ Yes ○ No

Please explain_____

_____

Child's VISION HISTORY:

Date of child's last eye exam _____ Does child now or has child ever worn glasses? ○ Yes ○ No

What kind ○ Single Vision ○ Bifocals ❑ ***When:*** ○ distance only ○ near only ○ full time

Has your child ever had **vision therapy**? ○ Yes ○ No

Child's HEALTH HISTORY: Check all conditions **that apply to your child** or that run in your family

ADD or ADHD	○ Yes child	○ Yes Family
Dyslexia	○ Yes child	○ Yes Family
Learning Disabilities	○ Yes child	○ Yes Family
Autism	○ Yes child	○ Yes Family
Cerebral Palsy	○ Yes child	○ Yes Family
Seizure Disorders	○ Yes child	○ Yes Family
Allergies	○ Yes child	○ Yes Family
Cancer	○ Yes child	○ Yes Family
Diabetes	○ Yes child	○ Yes Family
Drug sensitive	○ Yes child	○ Yes Family
Elevated Cholesterol	○ Yes child	○ Yes Family
Heart problem	○ Yes child	○ Yes Family
High blood Pressure	○ Yes child	○ Yes Family
Respiratory Disease	○ Yes child	○ Yes Family
Thyroid	○ Yes child	○ Yes Family
Headaches/Migraines	○ Yes child	○ Yes Family

Head trauma	○ Yes child	○ Yes Family
Lazy eye	○ Yes child	○ Yes Family
Blindness	○ Yes child	○ Yes Family
Crossed eyes	○ Yes child	○ Yes Family
Turned eye	○ Yes child	○ Yes Family
Color "blind"	○ Yes child	○ Yes Family
Light sensitive	○ Yes child	○ Yes Family
Eyestrain	○ Yes child	○ Yes Family
Dry eyes	○ Yes child	○ Yes Family
Floaters/spots	○ Yes child	○ Yes Family
Flashing lights	○ Yes child	○ Yes Family
Retinal detachment	○ Yes child	○ Yes Family
Cataracts	○ Yes child	○ Yes Family
Glaucoma	○ Yes child	○ Yes Family
Macular degeneration	○ Yes child	○ Yes Family
Eye surgery or injury	_____	

Child's Pediatrician or Doctor:

Dr.'s Name: _____ City: _____ Phone: _____

Date of your child's last physical _____ Is your child taking any medications regularly? ○ Yes ○ No

Specify Medications: 1_____ 2 _____ 3_____

4_____ 5_____ 6_____

How do you rate your child's general health? (Circle one) Excellent Good Fair Poor

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

Developmental Milestones

Full Term Pregnancy? ◯Yes ◯No Normal Birth? ◯Yes ◯No Explain_____

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

School-Related Vision Problems:

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

- ☐ Squints when looking up from reading?
- ☐ Has trouble seeing the chalkboard?
- ☐ Has trouble copying work from the chalkboard to paper?
- ☐ Frequently blinks or rubs eyes?
- ☐ Has headaches after doing school work?
- ☐ Frequently is awkward or clumsy, bumps into things or knocks things over?
- ☐ Holds books extremely close?
- ☐ Reads a great deal of the time?
- ☐ Reports that things look blurry?
- ☐ Spends "**hours**" doing homework that should take only a *few* minutes?
- ☐ Covers one eye by leaning on hand?
- ☐ Lays head on desk when doing pencil work?
- ☐ Frequently loses place when reading?
- ☐ Gets tired quickly when doing reading or homework?
- ☐ Skips or re-reads words or lines?
- ☐ Must re-read material several times to grasp its meaning?
- ☐ Reverses words or letters (was for saw, b for d) past second grade?
- ☐ Does better at Math than English, History or Social Studies?
- ☐ Short attention span? Can concentrate on close or near work for only a few minutes.
- ☐ Has a reduced attention span, can concentrate for only a moderate amount of time?
- ☐ 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?

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

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

RECREATION AND LEISURE: What recreational activities does your child participate in? *(Circle)*

☐Reads ☐baseball ☐basketball ☐soccer ☐swims ☐build models ☐sews ☐dances ☐performs ☐plays an instrument

Other sports or activities _____ Does your child wear protective eyewear? ◯**Yes** ◯**No**

Does your child . . .

Watch much TV? # of hours a day _____

Use a computer at home? # of hours a day _____

Use a computer at school? # of hours a day _____

Often play video games? # of hours a day _____

Play hand-held video games? # of hours a day _____

Screen type ◯Bright ◯Dim

Print & **Sign your name** : _____ **Date**: _____

Parent or Guardian's Signature

modified 6/2015