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Child's full name_____DOB_____ Present Age_____
Complete Address_____
Father's name_____ Home phone_____
Occupation_____ Business phone_____
Mother's name_____ Home phone _____
Occupation_____ Business phone_____
Siblings (age and gender)_____
Name of School_____Grade_____
Teacher's Name _____
Referred by _____
Reason for referral_____
Pediatrician's name _____
Pediatrician's phone number _____
Last medical exam _____ Allergies _____
Present medications_____

PRESENT SITUATION: In what ways does your child seem to have difficulty? How does your child complain about his or her vision?

_____

_____

Has anyone noticed an eye turn in or wander out? ☐ Yes ☐ No Which eye?_____When? _____

Does your child ever report any of the following, and if yes, when?

Headaches ☐Yes ☐No When _____ Eyes hurt or tired ☐Yes ☐No When _____
Blurred Vision Far ☐Yes ☐No When _____ Double Vision ☐Yes ☐No When _____
Blurred at Near ☐Yes ☐No When _____ Light sensitivity ☐Yes ☐No When _____

Have you ever noticed the following?

Holding reading close ☐Yes ☐No When_____ Distorted posture when reading? ☐Yes ☐No When_____
Holding reading further away ☐Yes ☐No When_____ Inability to see distance objects? ☐Yes ☐No When_____
Closing one eye? ☐Yes ☐No When_____ Bumping into objects? ☐Yes ☐No When_____
Covering one eye? ☐Yes ☐No When_____ Poor coordination/clumsiness? ☐Yes ☐No When_____
Eyes frequently reddened? ☐Yes ☐No When_____ Skips words or rereads ☐Yes ☐No When_____
Frequent styes? ☐Yes ☐No When_____ Reverses words/letters ☐Yes ☐No When_____
Excessive eye rubbing? ☐Yes ☐No When_____ Moves lips while reading quietly ☐Yes ☐No When_____
Get lost in book? ☐Yes ☐No When_____ Moves head while reading ☐Yes ☐No When_____
Uses finger to follow words ? ☐Yes ☐No When_____ Tilts head while reading ☐Yes ☐No When_____

Does your child have speech/language deficit? ☐Yes ☐No If yes, has any attempt been made to correct it? ☐Yes ☐No
By whom?_____ Was therapy successful? ☐Yes ☐No _____

PLEASE TURN OVER TO COMPLETE

Developmental History

Is the child adopted? ____ If yes, does the child know? _____ Age when adopted _____

Full term pregnancy?_____Normal birth?_____

Any complications before, during, or following delivery?_____

_____

Was the child exposed in utero to: □ drugs □alcohol □ nicotine

Did your child crawl? □Yes □No Age_____ Age at which child walked?_____

Age of speech: First words?_____Sentences?_____

When fatigued, child will: Sag_____Becomes irritable_____excited_____

Under tension, is there any pattern of behavior, thumb-sucking, etc? _____

_____

School

Age at time of entrance?_____Kindergarten_____First grade_____

Does child like school?_____Was a grade repeated?_____Which One?_____

Is school work? ☐ average ☐ better than average ☐ below average

Have there been any school difficulties? _____

What subjects are considered easiest?_____ most difficult?_____

Does test taking appear to cause anxiety□Yes □No _____

Does the school consider your child to have a learning problem? □Yes □No _____

_____

Does the school consider your child to have a discipline problem? □Yes □No _____

_____

Does your child like to read? □Yes □No

Visual History

How long has difficulty been noticed?_____

Previous visual examinations:

Reason for examination Doctor's Name Date Result

_____

_____

_____

Members of family who have had visual attention and why:

Name Age Visual Situation

_____

_____

_____

Give a brief description of your child as a person:

_____

_____

_____

As you complete this history questionnaire you will recognize the thoroughness with which your problem will be considered. The office examination will be as comprehensive as possible and further private or specialized services may be recommended if a visual developmental concern is noted. Your child's future deserves the fullest consideration that you as parents and we here in the office can provide.

Signature:_____Date:_____