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

Condition		
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?**)

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