

Vision develops in conjunction with other functions such as walking and talking and may be affected by illness or family history. It will be helpful for us to have complete answers to the following questions prior to your child's appointment. Thank you.

Name _____ Date of Exam _____
Address _____ ZIP _____
Telephone Home _____ Work/Cell _____
Date of Birth _____ Age _____ SSN _____
Child's Father _____ Mother _____
Parents: Married Separated Divorced Child lives with _____
Father's Address _____ ZIP _____
Mother's Address _____
Siblings (with ages) _____

Vision Insurance _____ Name of Insured _____
Medical Insurance _____ Name of Insured _____
Physician's Address _____
Physician's Telephone _____

Name of School _____
School Address _____
Grade _____ Teacher _____

Whom may we thank for referring you? _____

VISUAL HISTORY

1. My child is here today because:

<input type="checkbox"/> no problems—general check up	<input type="checkbox"/> squints a lot
<input type="checkbox"/> eye turns (circle one) IN or OUT	<input type="checkbox"/> eyes do not seem to focus
<input type="checkbox"/> rubs eyes a lot	<input type="checkbox"/> initial consult/visit
<input type="checkbox"/> family history of visual condition	<input type="checkbox"/> second opinion
<input type="checkbox"/> other _____	

2. In your own words, please state briefly your main concern about your child's difficulty and what has led you to request a visual examination for your child.

3. Last examination _____ Doctor _____
Results _____

4. Has your child ever had an eye injury Y/N _____

5. Has your child ever had an eye surgery Y/N _____

6. Does your child wear glasses Y/N Contact lenses Y/N What type? _____

7. Family History of any visual condition; please check all that apply and state relation.

- spectacle or contact lens correction _____
- amblyopia (lazy eye) _____
- strabismus (eye turn) _____
- poor color vision _____
- retinal detachment _____
- glaucoma _____
- macular degeneration _____
- cataracts _____
- other, please explain _____

GENERAL HEALTH INFORMATION

General health conditions can sometimes affect your vision or ocular health. Please complete as much of this section as you feel comfortable, or discuss these issues with your doctor during the exam.

How would you describe your child's general health? _____

Are there any known problems with any of these systems?

Eyes Y/N	Gastrointestinal Y/N	Nervous System Y/N
Ears/Nose/Throat Y/N	Genitourinary Y/N	Endocrine (glands) Y/N
Cardiovascular Y/N	Musculoskeletal Y/N	Blood/Lymph Y/N
Respiratory Y/N	Integumentary (skin) Y/N	Allergic/Immunologic Y/N
Psychiatric Y/N	HIV/AIDS Y/N	

Please explain any YES answers _____

Please answer all that apply.

Diabetes Y/N Type _____ Date of Diagnosis _____

Current medications _____

Medication allergy Y/N What happens? _____

List any environmental allergies _____

Headaches Y/N How often? _____

Other health problems? _____

Has your child had any operations? Y/N Specify type and date _____

Please explain anything else you feel we should know in order to best serve your child.

Please list where and to whom you would like any formal reports (other than parent) sent from this examination.

Name: _____ Name: _____

Address: _____ Address: _____

Patient (Parent or Guardian) signature _____

DEVELOPMENTAL HISTORY

1. My child is: ___natural___ adopted___ foster___ other _____
2. Are there any know genetic or familial disorders? ___NO ___ YES
Please explain _____
3. During the pregnancy of this child, were there any complications? ___NO ___ YES
Please explain _____
4. Was the child born prematurely? ___ NO ___ YES. If yes, what was the length of the pregnancy? _____
5. Type of delivery ___ natural ___ Caesarian ___ forceps or instruments ___ anesthesia other, please explain _____
6. What was the child's birth weight? _____
7. Was there any use of cigarettes, alcohol, drugs, or medications during the pregnancy? ___ NO ___ YES, please explain _____
8. At what age did your child:
 - a. crawl on all fours? _____
 - b. pull himself up to chairs and tables? _____
 - c. begin to walk? _____
 - d. first make speech sounds _____
9. Was your child's speech clear? _____ Could others besides the family understand your child's early speech? _____
10. Is your child's speech adequate now? _____
11. Can your child:
 - a. dress himself? _____
 - b. button clothes? _____
 - c. tie bows? _____
 - d. zip zippers? _____
 - e. lace shoes? _____
12. Does your child have or at one time had any behavioral problems such as temper tantrums, self-destructive behavior, difficulty sleeping, etc? ___NO ___ YES, please explain _____
13. What hand does your child use for eating, writing, or throwing ? _____
Has the child always used this hand? _____
Was any guidance given? _____
14. Which foot does your child use for kicking? _____ Hopping? _____
15. Has your child ever worn any type of brace? _____ Casts/Crutches? _____
If yes, please explain _____