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GENERAL INFORMATION

Name _____ Date of Birth _____

Parent's Names _____ Patient's Social Security # _____

Address _____
STREET APT. NO.

CITY STATE ZIP Phone _____

How did you hear about our office? _____

Primary reason/concern for today's visit _____

MEDICAL HISTORY

Was birth full-term? _____ Weeks early/late _____ Birth weight _____

Any complications during pregnancy or delivery? _____

Normal development? _____ Walked at what age? _____

Current health problems _____ Current medications _____

Allergies? _____ Pediatrician _____

Major childhood illnesses or hospitalizations _____

Family history of: Diabetes _____ Glaucoma _____ High Blood Pressure _____ Eye Problems _____

ACADEMIC HISTORY

School name and address _____

Grade _____ Teacher _____ Has a grade ever been repeated? _____

Does child perform at expected levels for age in school? _____

Problem areas: Reading _____ Math _____ Spelling _____ Writing _____ Other _____

Does child enjoy school? _____ Has child had any tutoring/remedial work? _____

Has a psychological evaluation been performed? _____

VISUAL HISTORY

Last complete vision exam: Doctor's name _____ Date _____

Results _____ Were glasses prescribed? _____ Are they worn? _____

Does child complain of or do you notice: (please check)

- _____ Blurry vision distance/near
- _____ Headaches
- _____ Eyestrain
- _____ Double Vision

- _____ Turned eye in/out constantly/sometimes
- _____ Skipping/re-reading of lines while reading
- _____ Letter reversals: b vs. d
- _____ Word reversals: was vs. saw

- _____ Poor hand-eye coordination
- _____ Gets very close to near work
- _____ Short attention span
- _____ Avoids near work