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NYC Pupil Www.NYCPupil.com

CHILD HEALTH HISTORY:

Child's Full Name:_____ Preferred Name:_____

Mother/Caretaker's Name:_____ Occupation:_____ Bus. Phone:_____

Father/Caretaker's Name:_____ Occupation: _____ Bus. Phone: _____

Address (if we don't already have it): _____

Your Child's Medical History:

Pediatrician's Name:_____ Is your child especially afraid of Doctors? Yes☐ No☐

Last Visit Date:_____ For what reason?_____ Is your child generally healthy?_____

Medications (including vitamins and supplements):_____

_____

Allergies to Medications:_____

List significant illnesses, bad falls, high fevers or chronic illnesses (asthma, allergies, frequent colds, ear infections)

Event/Condition Age Severity Describe any complications

_____

_____

Has a neurological/psychological evaluation been performed? Yes☐ No☐ By Whom?_____

Has an occupational therapy evaluation been performed? Yes☐ No☐ By Whom?_____

Is there any history of the following? (please check if there is a history)

	Child	*Family*	*If Family, Who?*		*Child*	*Family*	*If Family, Who?*
Poor vision/Rx	☐	☐	_____	Epilepsy/Seizures	☐	☐	_____
Strabismus	☐	☐	_____	Learning Issue	☐	☐	_____
Amblyopia	☐	☐	_____	Blindness	☐	☐	_____
Cancer	☐	☐	_____	Other _____	☐	☐	_____

Do you notice or has your child complained of any of the following:

Eye turns in/out	Y*	N	Eyelid Droops	Y	N
Squints/blinks a lot	Y	N	Poor tracking/eye movements	Y	N
Covers/closes one eye	Y*	N	Head tilt/Face turn	Y	N
Lacks interest in looking at objects	Y	N	Repeatedly flicks objects		
Rubs eyes excessively	Y	N	in front of face	Y	N
Reddened or encrusted eyelids	Y	N	Stumbles over objects or is clumsy	Y	N
**If yes, please complete strabismus/amblyopia history*			Poor motor control	Y	N

Medical History/System Review:

Does your child have or has your child had:

Any eye injury or surgery	Y*	N	Surgery/hospitalizations	Y	N
Any lazy eye/amblyopia	Y*	N	Breathing problems	Y	N
Any patching	Y*	N	Gastrointestinal problems	Y	N
Any vision therapy/orthoptics	Y*	N	Musculoskeletal problems	Y	N
Neurological problems	Y	N	Ear/nose/throat problems	Y	N
Development delayed	Y	N	Head Injury/ Trauma	Y	N

**If yes, please complete strabismus/amblyopia history*

Your Child's Developmental History:

Length of pregnancy: ___ mos. Type of delivery:___ Natural ___Caesarian ___Forceps/vacuum ___ Anesthesia

During pregnancy of this child, did any of the following occur:

___ toxemia ___ injury by fall ___ severe illness ____other
___ trauma ___ smoking ___ prescribed medication
___ use of alcohol ___ use of drugs ___ little obstetrical care
Please explain: _____

Child's birth weight: _____ lbs. and ozs. Apgar score _____@ birth _____ after 10 min

My child is: _____ biological
_____ adopted _____ foster At what age?: _____
_____ other_____

Please rate your child on the following skills/milestones:

	ACTIVITY	AVERAGE AGE	EARLY	LATE	NORMAL	UNSURE
	Gross Motor Development					
1.	Rolled over	3.5 Months	_____	_____	_____	_____
2.	Sits w/out support	6.5 Months	_____	_____	_____	_____
3.	Walks unaided/alone	12 Months	_____	_____	_____	_____
4.	Kicks a ball	18 Months	_____	_____	_____	_____
5.	Toilet Trained	24 Months	_____	_____	_____	_____
6.	Rides tricycle	3 years	_____	_____	_____	_____
	Fine Motor Development					
1.	Reaches/Grasp for object	4 Months	_____	_____	_____	_____
2.	Scribbles spontaneously	15 Months	_____	_____	_____	_____
3.	Stacks/Piles blocks	18 Months	_____	_____	_____	_____
4.	Eats with a fork/spoon	24 Months	_____	_____	_____	_____
	Language Development					
1.	Smiles spontaneously	1 Month	_____	_____	_____	_____
2.	Says single words	12 Months	_____	_____	_____	_____
3.	Refers to self by first name	18 Months	_____	_____	_____	_____
4.	Knows full name	3 Years	_____	_____	_____	_____

Current Grade in School: _____ What School do they go to: _____
Favorite Subject: _____

How is your child performing compared to others his/her age: Above average☐ Average☐ Below average☐
How well developed is your child's spoken vocabulary? _____

Has your child undergone any of the following testing/treatment/therapy?

Educational	Yes☐	No☐	Neurological	Yes☐	No☐	Psychological	Yes☐	No☐
Occupational	Yes☐	No☐	Speech/Auditory	Yes☐	No☐	Physical	Yes☐	No☐

If yes, please list all previous evaluations done on your child:

Doctor or Institution	Date(s)	Type of Evaluation	Results/Treatment/Intervention
_____	_____	_____	_____
_____	_____	_____	_____

Visual History:
Main reason for having an examination today: _____

Date of Last Evaluation: _____ Doctor's Name: _____

Reason for examination: _____

Results/recommendations: _____
Were glasses, contact lenses or other optical devices recommended? Yes ☐ No ☐
If yes, are they used? Yes ☐ No ☐ If yes, when? _____ **3/3**
If no, why not? _____

Do you observe or does your child report any of the following:

YES

☐Headache
☐Blurred Vision
☐Double Vision
☐Eyes "hurt" or "tired"
☐Nausea when doing visual tasks
☐Motion sickness or car sickness
☐Bothered by light / sunlight
☐Frequent styes
☐Eyes itch

YES

☐Eyes burn
☐Eyes tear
☐Eyes frequently reddened
☐Closing or covering and eye *
☐Loses place while reading *
☐Poor reading comprehension *
☐When reading, letters/words appear to move or float *

☐Loses attention easily *

**Please fill out the reading/computer questionnaire*

Are there any other complaints your child makes concerning their vision? _____

_____

Do you have any other concerns/observations concerning your child's vision? __

_____

Were you referred to our office? Yes ☐ No ☐ Whom may we thank for this referral? _____
Referral address:_____Phone:_____
If not referred, how did you hear about us? _____

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STRABISMUS/AMBLYOPIA HISTORY (for children or adults with a lazy eye, eye turn or crossed or wandering eye)

At what age was the eye turn first noticed? _____
Did it start suddenly or gradually? _____
Which direction does the eye turn (check all that apply)? ☐ In ☐ Out ☐Up ☐Down
Which eye turns ? ☐Right ☐Left ☐Both
Is the eye turn getting worse, better or no change? _____
When does the eye turn (always, what % of the time, when tired, when ill, etc…): _____
Does the eye turn more when looking: ☐up close ☐in the distance ☐to the left ☐to the right ☐up ☐down
Do you ever notice one or both eyes shaking rapidly? _____
If patching treatment was prescribed, please describe at what age patching was started, how it was done, the eye patched, for how long, and an estimate of the result

_____

_____

_____

_____

Has there been any surgery? _____
If yes, estimate the results: _____
Please describe any visual therapy, including duration of treatment, age at which it was started and estimate the results: _____

_____

_____

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DIZZINESS AND MOTION SENSITIVITY CHECKLIST

(Dizziness, motion sickness, car sickness, etc…)

Check all symptoms that are significant for you:

☐Nausea, headache or dizziness when reading in the car even on a STRAIGHT road
☐Nausea, headache or dizziness when sitting close to movie screen or watching a train go by
☐Hyper-sensitive to light (store lights seem bright, tend to wear sunglasses even on cloudy days)
☐Frequent, sometimes daily, headache or "pressure" in your head
☐Nausea, headache, dizziness or spacey feeling when shopping or moving through crowds of people
☐Unusual fear of heights
☐Lose your place easily when reading
☐Flickering lights bother you (light through trees when driving or fluorescents)
☐Avoidance of driving because of car sickness

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If not referred, how did you hear about us? _____