



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	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strabismus	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning Issue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 in front of face	Y	N
Rubs eyes excessively	Y	N	Stumbles over objects or is clumsy	Y	N
Reddened or encrusted eyelids	Y	N	Poor motor control	Y	N

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

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? _____

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: _____

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

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? _____