DEAR PARENTS/GUARDIANS:

Your child's vision develops in conjunction with such other functions as walking and talking. It also can be affected by certain illnesses, as well as his/her family history. Therefore, your thorough answers to these forms will aid us in determining how your child's vision has developed as well as permitting us to utilize all of the office time for a complete optometric examination.

Child's Full Name: ____

Address: ______________________________City_____________Zip_______

Date of Birth:____________AgeNow:____

Grade:____School:_________________Teachers Name: ___________________

Mother's Name: _______________________ Employer: ___________________

Home Phone: (   ) _________________ Work Phone: (   ) _________________

Cell Phone (   )____________________ Best way to contact:________________

Father's Name: ________________________ Employer: ___________________

Home Phone: (   ) _________________ Work Phone: (   ) _________________

Cell Phone (   )_____________________Best way to contact:________________

Who does the child reside with: Mother- Father- Both or Other______________

Siblings names and ages:____

Who recommended you to our office? _____________________________________

For what reasons? ____

A. Present Situation:

1. Does your child seem to have any visual difficulty? _____________________
   If yes, in what way? ____
   ____

2. How long has this difficulty been noted? (if it is present) _________________

3. Does your child ever report any of the following, and if so, when?
   a. Headaches: Yes: _____ No: _____ When? _________________
   b. Blurred vision: Yes: _____ No: _____ When? _________________
   c. Double vision: Yes: _____ No: _____ When? _________________
   d. Eyes "hurt or tired": Yes: _____ No: _____ When? _________________

4. Have you or anyone else ever noted the following:

Symptoms	Yes	No	When
a. Holding reading close			
b. Uses finger when reading			
c. Reverses words			
d. Skips words			
e. Closes or covers on eye			
f. Frowning or squinting			
g. Eyes frequently reddened			
h. Frequent sties			
i. Excessive eye rubbing			
j. Getting lost in books (Not aware of surroundings)			
k. Tilting head when reading			
l. Bumping into objects			
m. Poor General Coordination			
n. Large pupils in bright light			
o. Bothered by light			
p. "Car Sickness"			

B. SCHOOL

1. Age at time of entrance? Kindergarten _____________ First Grade _________
2. Does your child like school? Yes____ No ____ Teacher? Yes ____ No ____
3. Has a grade been repeated? Yes ____ No ____ Which? ____
4. Has there been any school difficulty? Yes ____ No ____
5. If Yes, Explain ____
   ____
6. Is schoolwork above average _____________, average _____________ or below average _____________.
7. Is there any subject(s) which seem easy for the child? ___________________
8. Is there any subject(s) which seem difficult for the child? _________________
9. Is the child in any special classes, such as math or reading? _____________
10. Does your child like to read? ____

C. DEVELOPMENTAL HISTORY

1. Full-term pregnancy? _________________ Normal Birth? _________________
   Any complications before, during or immediately following delivery?
   ____
   ____
2. Did you child crawl? _________________ On all fours? ___________________
   At what age? ____________
3. At what age did your child walk? ________________
4. Speech: First words? Age ___________ Sentences? Age _________
5. Was your child active? ____________________
6. When fatigued, your child does which of the following?
   Sags _________ Becomes irritable __________ Becomes excited __________
7. When under tension, is there any pattern of behavior, such as thumb sucking, nail biting, etc.? ____

D. GENERAL HEALTH

1. Past illnesses (as measles) and significant injuries:

Illness or Injury	Age	Mild	Severe

2. Health at present: Good _________ Fair _________ Poor _________
3. Is your child receiving medication now? _________ Purpose _______________
4. Teeth condition? ____
5. Condition of tonsils? ____
6. Has your child had all of their vaccinations?
   ____

CONTINUE TO NEXT PAGE

E. VISUAL HISTORY

1. Have your child's eyes ever been crossed or turned out? ________________
2. Previous visual examinations:

Reason for examination	Date	Doctor	Results

3. Members of the family who have had visual attention and why? ____________
____
____
____
____
____
____

4. Are there any unusual family eye conditions? ___________________________
____
____

F. Please give a brief description of your child's personality.

Thank you.