Additional History for Young Patients

Please answer as many of the following questions as you can.

Patient Name:____ Grade:________________

Parent/Guardian Name:____

Eye Information

Have you ever noticed any of the following symptoms with your child? ☐ None of these apply

- ☐ Eye turn in
- ☐ Eye turn out
- ☐ Eyes watering
- ☐ Swelling around eyes
- ☐ Rubbing eyes a lot
- ☐ White appearance of pupil
- ☐ Complains of blurred vision
- ☐ Complains of double vision
- ☐ Closing or covering one eye
- ☐ Holding books too close
- ☐ Tilting/turning head
- ☐ Confuses letters or words
- ☐ Reverses letters or words
- ☐ Skips or re-reads words
- ☐ Reads slowly
- ☐ Headaches with reading
- ☐ Uses finger as marker
- ☐ Poor reading comprehension
- ☐ Writes or prints poorly
- ☐ Tires easily
- ☐ Avoids close work
- ☐ Short attention span
- ☐ Poor motor coordination
- ☐ Poor hand-eye coordination

Development Information

Was the pregnancy longer than 36 weeks? ☐Y ☐N

Were there any problems during the pregnancy? ☐Y ☐N

Were there any problems during the delivery? ☐Y ☐N

At about what age did your child begin to do the following: Walk _______ Talk _____ Crawl _____

School Child not in school yet

Has your child had to repeat any grades? ☐Y ☐N

Has your child received any special tutoring/remedial services? ☐Y ☐N

Has your child ever received physical therapy services? ☐Y ☐N

Has your child ever received speech therapy services? ☐Y ☐N

Has your child ever received occupational therapy services? ☐Y ☐N

Has your child ever received any other therapy services? ☐Y ☐N

Has a neurological evaluation ever been performed? ☐Y ☐N

Has a psychological evaluation ever been performed? ☐Y ☐N

Does your child like school? ☐Y ☐N

Does your child like to read? ☐Y ☐N

Do you feel he/she is working up to their potential? ☐Y ☐N

Additional information (including names of specialists/therapists) ____________________________________

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Would you like us to send reports of our findings to any of the individuals listed above? ☐Y ☐N

If yes, please provide name and address, if known.

Name ____________________________________ Name ____________________________________

Address __________________________________ Address __________________________________

City/ST/Zip _______________________________ City/ST/Zip _______________________________

If additional space is needed, please continue on the back

Please sign below to give us permission to release information about your child to the individuals above.

(Valid for 90 days only) Signature _______________________________ Date _______________________

May we use drops to dilate your child's eyes in order to find their glasses prescription? ☐ Y ☐N

Signature__________________________________ Date______________________