

Please take a few minutes to fill out this form. The information will make for better use of our appointment time. Also it will tell us what examination routines will best apply to your child's problem. This information is confidential and will not be released without your consent.

Child's full name \_\_\_\_\_  
 Nickname \_\_\_\_\_ Sex F M Age \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_  
 Name of School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_  
 1<sup>st</sup> Parent's Name \_\_\_\_\_ Occupation \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 2<sup>nd</sup> Parent's Name \_\_\_\_\_ Occupation \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Present situation:

1. In what way does your child seem to have visual difficulty?
  
2. How does your child complain about his/her vision?

Does child report or have you or anyone else ever noted	Yes	No	If yes, when?
1. Headaches			
2. Blurred Vision			
3. Double Vision			
4. Eyes 'hurt' or 'tired'			
5. Holding reading close			
6. Closing one eye			
7. Covering one eye			
8. Eyes frequently bloodshot			
9. Frequent styes			
10. Excessive eye rubbing			
11. Excessive blinking			
12. Getting lost in a book (not aware of surroundings)			
13. Tilting head when reading			
14. Inability to see distant objects			
15. Bumping into objects			
16. Poor general coordination			
17. Large pupils in normal light			
18. Bothered by light			
Other:			

**School:**

1. Age at time of entrance to: Kindergarten? \_\_\_\_\_ First Grade? \_\_\_\_\_
2. Does child like school? \_\_\_\_\_ Does child like teacher? \_\_\_\_\_
3. Has a grade been repeated? \_\_\_\_\_
4. Have there been any school difficulties? \_\_\_\_\_
5. Is school work: Average \_\_\_\_\_ Above average \_\_\_\_\_ Below average \_\_\_\_\_
6. Are there any subjects which seem particularly easy for the child? \_\_\_\_\_
7. Are there any subjects which seem particularly hard for the child? \_\_\_\_\_

**Developmental History:**

1. Was pregnancy full term? \_\_\_\_\_ Was birth normal? \_\_\_\_\_
2. Complications before, during, or immediately follow delivery: \_\_\_\_\_
3. Did your child crawl? \_\_\_\_\_ All fours? \_\_\_\_\_ Age? \_\_\_\_\_
4. At what age did child walk? \_\_\_\_\_
5. First words? \_\_\_\_\_ Age? \_\_\_\_\_
6. Was child active? \_\_\_\_\_
7. When fatigued does child? Sag \_\_\_\_\_ Become irritable \_\_\_\_\_ Become excited \_\_\_\_\_
8. When under tension, is there any pattern of behavior, such as thumb sucking, nail biting, etc.?  
\_\_\_\_\_

9. List major illnesses	Age	Severity		
		Mild	Moderate	Severe
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Visual History:**

1. How long has difficulty been noticed? \_\_\_\_\_
2. Previous visual examinations?    Age            Doctor's Name            Results  
\_\_\_\_\_  
\_\_\_\_\_

3. Family members who have had visual attention    Age            Visual Situation  
\_\_\_\_\_  
\_\_\_\_\_

**Give a brief description of child's personality:**

As you complete this history you will recognize the thoroughness with which your child's problem will be considered. The office examination will be a sufficient length to permit a very complete optometric investigation of the problem. Some parents have told us that being in the exam room during the evaluation was very helpful. If possible both parents may want to be present so that they will understand the child's needs and the doctor's observations and suggestions.

Thank you, Dr. Rebecca E Hutchins, O.D.