VISION CARE CENTER

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PATIENT HISTORY FORM

Please complete the following questionnaire as completely as possible. The information will help to plan for the evaluation and to determine you child's needs. Please return the questionnaire prior to coming in for your scheduled appointment. Please include any additional information, testing and/or reports that may be relevant to the evaluation.

QUESTIONNAIRE **DATE**_________________

CHILD'S INFORMATION

Name____
Last First Middle

Birth Date_________________________Age_______________Sex______________
Month Day Year Year Month

Address_______________________________________Phone:_________________
Street

____
City State Zip

School________________________Grade____________Phone:__________________
Name

Teachers:___________________________Subject:_____________________________
___________________________ _____________________________
___________________________ _____________________________

How did you hear about us? ______________________

Primary Care Physician/Pediatrition:____

PARENT AND FAMILY INFORMATION

Father's Name____________________________Birth Date:____________________
Address:_________________________________Phone:_______________________
(If different from child's)
Occupation/Title:___________________________Day Phone:___________________

Mother's Name____________________________Birth Date:____________________
Address:_________________________________ Phone:_______________________
(If different from child's)
Occupation/Title:___________________________Day Phone:___________________

Guardian's Name______________________________Birth Date:_____________________
Address:_____________________________________Phone:_________________________
(If different from child's)
Occupation/Title:_____________________________Day Phone:_____________________

Marital Status of Parents:

( ) Married
( ) Separated/divorced _____yrs.
( ) Father deceased _____yrs.
( ) Mother deceased _____yrs.

Family Structure:

Mother		Father
( )	Natural Parent	( )
( )	Adopted Parent	( )
( )	Foster Parent	( )
( )	Other, specify	( )

Parents Education:

Levels Completed	Mother	Father
Grade School	( )	( )
High School	( )	( )
College or equivalent (years)	( )______	( )______
Graduate Work	( )	( )

Ordinal Position of Child: (i.e. 3rd of 6 = 3/6) ___________________________________

Siblings:

Name	Age	Adopted		Difficulty in School	
		Yes	No	Yes	No
______________________	______	( )	( )	( )	( )
______________________	______	( )	( )	( )	( )
______________________	______	( )	( )	( )	( )

Comments:
____
____
____

Number of household moves in child's lifetime:__________________________________

PRESENT SITUATION

Reason for Evaluation:
____
____
____

Who first noticed the child's problem/When?___________________________________
Did problems occur suddenly?____
Do his/her problems seem to be related to illness, accident, or other trauma?____

Academic Problems	None	Moderate	Severe	Grade Level
Reading	( )	( )	( )	___________
Spelling	( )	( )	( )	___________
Writing	( )	( )	( )	___________
Arithmetic	( )	( )	( )	___________
Physical Education	( )	( )	( )	___________
Science	( )	( )	( )	___________
History	( )	( )	( )	___________
Other,specify_______________	( )	( )	( )	___________

What do you feel is the reason(s) for these problems?_____________________________
____

Age of entrance into kindergarten? _____________yrs. _____________months
Did child ever repeat a grade?________________If yes, which?______________________
Does child like school?_________Teacher?__________Fellow students?______________
What is child's favorite subject(s)?____
Least favorite?____
Has your child had any remedial work?____
When?___________________________In What?__________________________________
From Whom?_____________________Effects?___________________________________

Additional comments on problems in school and history?__________________________
____
____
____

BEHAVIOR CHARACTERISTICS

Observations	Never	Sometimes	Often
Restless	( )	( )	( )
Lacks self-confidence	( )	( )	( )
Short attention span	( )	( )	( )
Hyperactive (always on the go)	( )	( )	( )
Hypoactive (passive)	( )	( )	( )
Irresponsible-undependable	( )	( )	( )
Requires frequent naps	( )	( )	( )
Irregular bedtimes	( )	( )	( )
Needs large amounts of sleep	( )	( )	( )
Difficulty settling down for sleep	( )	( )	( )
Extreme fatigue	( )	( )	( )
Nervous, jittery, jumpy	( )	( )	( )
Eats large amounts of sweets	( )	( )	( )
Temper tantrums	( )	( )	( )
Attention-seeking (shows off)	( )	( )	( )
Jealous of attention of other children	( )	( )	( )
Anxiety (fearfulness)	( )	( )	( )
Specific fears _________________	( )	( )	( )
Sucks thumb	( )	( )	( )
Bites nails	( )	( )	( )
Wets bed	( )	( )	( )
Stutters	( )	( )	( )
Cries over minor annoyances, hurts	( )	( )	( )
Feelings easily hurt	( )	( )	( )
Tense, uptight	( )	( )	( )
Shy, bashful	( )	( )	( )
Difficulty in making friends	( )	( )	( )
Disoriented and confused	( )	( )	( )
Lacks enthusiasm	( )	( )	( )
Self conscious, easily embarrassed	( )	( )	( )
Day dreams	( )	( )	( )
Easily led by others	( )	( )	( )
Boisterous, rowdy	( )	( )	( )
Uncooperative	( )	( )	( )
Fighting, hot-tempered	( )	( )	( )
Negative attitude	( )	( )	( )
Profane language	( )	( )	( )
Disruptive	( )	( )	( )

ORGANIZATION	Never	Sometimes	Often
Trouble keeping on tasks	( )	( )	( )
Does not finish attempted tasks	( )	( )	( )
Does not plan time well	( )	( )	( )
Seeks excessive attention for help	( )	( )	( )
Disorganized, messy work	( )	( )	( )

PLAY/SPORTS ACTIVITIES	Yes	No
Does child leisure read?	( )	( )
Does child like to read?	( )	( )
Does child like to be read to?	( )	( )
Does child watch television?	( )	( )
Listen to music?	( )	( )
Participate in rhythm activities (jump rope, dancing, pattycakes, etc.)	( )	( )
Participate in ball activities (baseball, basketball, etc.)	( )	( )
Does child like erector sets, puzzles, coloring, etc.	( )	( )

In general, does child prefer indoors or outdoors activities?_________________________

MEDICAL HISTORY	Yes	No
Major illness or trauma	( )	( )

If yes, explain____

____

____

Usage of internal medication during pregnancy	( )	( )

If so, what?_______________________

Did your child crawl?	( )	( )
Excessive alcohol or drug use?	( )	( )
Excessive smoking?	( )	( )
Was child active in utero?	( )	( )

Length of pregnancy_________Birth Weight______lbs.______oz. Length__________in.

Labor – spontaneous, no complication?____

If no, explain____

Forceps___________Breech____________Ceasarean___________Natural___________

VISUAL HISTORY

Have parents or other children had visual attention and care?________________________

Relationship___________Age_____Why?_________________________________

Relationship___________Age_____Why?_________________________________

Relationship___________Age_____Why?_________________________________

Do any family members have eye disease or abnormalities?__________________________

If yes, explain____

____

Does child have glasses now?__________Does he/she wear them?___________________

If yes, when?____

Does child complain of:	Yes	Sometimes	No	When
Headaches	( )	( )	( )	____________________
Blurred vision (far)	( )	( )	( )	____________________
Blurred vision (near)	( )	( )	( )	____________________
Double Vision	( )	( )	( )	____________________
Eye strain	( )	( )	( )	____________________
Bright Lights	( )	( )	( )	____________________
Other______________________	( )	( )	( )	____________________
Have you noticed your child:				
Rubbing his/her eyes	( )	( )	( )	____________________
Excessive Blinking	( )	( )	( )	____________________
Red Eyes	( )	( )	( )	____________________
Sitting too close to TV	( )	( )	( )	____________________
Other:______________________	( )	( )	( )	____________________
When child reads or writes do they:				
Reverse letters	( )	( )	( )	____________________
Reverse words	( )	( )	( )	____________________
Skip or repeat words	( )	( )	( )	____________________
Keep place with finger	( )	( )	( )	____________________
Move head excessively	( )	( )	( )	____________________
Lose place on page	( )	( )	( )	____________________
Close or cover one eye	( )	( )	( )	____________________
Tilt or turn head	( )	( )	( )	____________________
Can child read/write for long periods of time?	( )	( )	( )	____________________

PLEASE REQUEST COPIES OF ALL PREVIOUS EVALUATION REPORTS BE SENT TO OUR OFFICE PRIOR TO EVALUATION DATE TO COMPLETE OUR HISTORY OF YOUR CHILD. Thank you.

PLEASE ADD ANY ADDITIONAL COMMENTS OR INFORMATION ON THE REVERSE SIDE.

Signature:___________________________________Date:______________________