

Name: _____

Date: _____

Children's History

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

Is this the child's 1st complete vision examination?

Yes No

If NO, where and when was the last examination?

DEVELOPMENTAL INFORMATION

Problems during pregnancy? Yes No

Problems during delivery? Yes No

Birth premature? Yes No

Number of weeks premature:

Birth weight:

Delivery type: Vaginal C-Section

Any fever greater than 103 degrees? Yes No

Age your child started walking?

Age your child started talking?

COORDINATION INFORMATION

Eye-hand coordination problem? Yes No

Problem with throwing/catching a ball? Yes No

Problem with handwriting? Yes No

FUNCTIONAL INFORMATION

Problem recognizing colors? Yes No

Problem recognizing numbers? Yes No

Problem recognizing letters? Yes No

Problem with letter/word reversals? Yes No

VISUAL HISTORY

Has an eye ever been patched? Yes No

Is there a problem with an eye turn? Yes No

Does your child cover an eye when looking at story books? Yes No

Does your child wear eyeglasses? Yes No

Does your child wear contacts? Yes No

PEDIATRICIAN INFORMATION:

Practice Name:

Doctor's Name:

Address:

THERAPY INFORMATION

Has your child been involved with:

Vision Therapy? Yes No

If YES where:

If YES when:

Speech Therapy? Yes No

Occupational Therapy? Yes No

Physical Therapy? Yes No

SCHOOL INFORMATION

Grade in school:

School Name:

Teacher's Name:

Eye strain with reading? Yes No

Eye rubbing with reading? Yes No

Headaches with reading or close work? Yes No

Reading comprehension problems? Yes No

Skipping lines when reading? Yes No

Re-reading lines? Yes No

Special class for any subject? Yes No

Repeated grade? Yes No

Best subject and grade in that class:

Hardest subject and grade in that class:

Anything else we should know? Yes No
