PATIENT HISTORY

Date: ____________________

Patient Information

Patient's Full Name: ______________________________ Male_____ Female_____
Address______________________________ Home Phone______________________
City______________________ State__________ Zip______________ Cell Phone______________________
Birth Date: ______________________________ Age: Years _______ Months ______ Grade: __________
School: ______________________________ Address: ______________________________
Teacher: ______________________________ Principal: ______________________________

Parent Information

Father's Name______________________________ Date of Birth______________________
Address______________________________ Home Phone______________________
City______________________ State__________ Zip______________ Cell Phone______________________
E-mail address______________________________ Business Phone ______________________
Place of Employment______________________________ Occupation______________________

Mother's Name______________________________ Date of Birth______________________
Address______________________________ Home Phone______________________
City______________________ State__________ Zip______________ Cell Phone______________________
E-mail address______________________________ Business Phone______________________
Place of Employment______________________________ Occupation______________________

How Did You Hear About Us?

☐ Seminar ☐ Newspaper ☐ Magazine ☐ T.V ☐ Internet ☐ Friend ☐ Doctor

Referral Information

Were you referred? No Yes By whom?______________________________
Address______________________________ Phone______________________

General Information

What is the main reason you are bringing your child to our office? Please be specific. ________________
____
____
____

Present Situation

Is there any evidence from the school or psychological test that indicates some visual malfunction may be present? No Yes If yes, what? ______________________________
____
____

List any other complaints your child makes concerning his/her vision.
____
____
____

School

Age at time of entrance to Kindergarten _____

to First Grade _____

Does your child like school? No Yes

Has your child changed schools often? No Yes

If yes, when? ____

Does your child seem to be under tension or extreme pressure when doing school work? No Yes

What school subjects are easy for child?____

What school subjects are difficult for child? ____

Does your child like to read? No Yes

What does your child like to read?____

School work is: Above average _____ Average _____ Below average _____

Do you feel your child is achieving to potential? No Yes

Does the teacher feel your child is achieving up to potential? No Yes

Has your child had any special tutoring and/or remedial assistance? No Yes

If yes, where and when?____

Result____

General Behavior

Is your child in constant motion? No Yes

Can your child sit still for long periods? No Yes

Are there any behavior problems at school? No Yes

Are there any behavior problems at home? No Yes

What causes these problems? ____

Visual History

Does your child have any visual or ocular problems/disease? No Yes

If yes, please describe____

____

Date of Last Eye Exam____________________ Doctor_______________________________

Address____

Reason for examination and exam results____

____

Were glasses prescribed? No Yes If yes, when are they worn?_________________________

List family members with visual problems (i.e. parents, siblings, grandparents, aunts, uncles, and cousins)

Name	Age	Visual Situation

Medical History

Physician's Name____ Phone ____________________

Is your child generally healthy? No Yes

List current diagnoses, treatment, medications ____

____

____

____

List major illnesses, ear infections, tubes, asthma, allergies, head injuries, high fevers, etc.

Age Incident Complications

____

____

____

____

____

____

____

____

____

Has your child been diagnosed with Autism or with Pervasive Developmental Disorder? No Yes

Has a neurological evaluation been performed? No Yes By whom?_____________________________

Results____

Has a psychological evaluation been performed? No Yes By whom?_____________________________

Results____

Developmental History

Full-term pregnancy? No Yes Birth weight: ____________________

Caesarean section? No Yes

Were forceps used? No Yes

Birth trauma? No Yes

Any complications before, during or immediately following delivery? No Yes

If yes, please describe ____

____

____

Did your infant crawl (stomach on floor)? No Yes At what age? __________________________

Did your infant creep (stomach off floor)? No Yes If other, describe ______________________

____

At what age did your child walk? __________________

Was your infant active? No Yes

At what age did your child talk? __________________

Was early speech clear to others? No Yes

Is it clear now? No Yes

Child's dominant hand? Right Left Both

Any adverse reactions to vaccinations? No Yes If yes, which vaccine? _______________________

What occurred? ____

____

____

Television Viewing

How much?___________________ How often?___________________ Viewing distance?___________________

Family and Home

Please indicate which adult(s) your child lives with:

Mother Father Stepmother Stepfather Foster Parents Adoptive Parents

Grandmother Grandfather Other (please describe) ______________________________________

Number of Brothers _____ Number of Sisters _____

Has your child ever been through a traumatic family situation (i.e. divorce, parental loss, separation, severe parental illness)? No Yes At what age? _____ Please explain ________________________

Does your child seem to have adjusted? No Yes

Is family life stable at this time? No Yes________________________

How does your child get along with parents? ____

With siblings? ____

With classmates?____

With playmates at home?____

Did father or anyone in father's family have a learning problem? No Yes

Who?____

____

Did mother or anyone in mother's family have a learning problem? No Yes

Who?____

____

Do any, or did any, other children in the family have learning problems? No Yes

Who?____

____

To what extent?____

Additional Comments:

Patient's Name ____

Release of Information

No Yes I agree to permit information from, or copies of, my child's examination records to be forwarded to other professionals (i.e. teachers, health care providers, or insurance carriers) when it is necessary for the treatment of my child's visual condition or for the processing of insurance claims.

I request that the following individuals be allowed access to information pertaining to this child (i.e. grandparents, music teacher, coach). Note: You may change this list at any time.

1.____
2.____
3.____
4.____
5.____
6.____

Financial Statement

I understand that all fees are due at the time of the exam unless prior arrangements have been made. I agree to pay the normal charges for these medical services. If it becomes necessary, I agree to pay all costs of collection, including attorney fees.

____ ______________________

Parent's or Guardian's Signature **Date**

____ ______________________

Witness **Date**

Patient:____**Date:** __________________

Performance Questionnaire

Please check all that apply concerning your child's behavior/performance.

Awareness Judgments

___ Interrupts often
___ Often misjudges situations
___ Misses details when reading
___ Has poor social awareness skills
___ Has trouble recognizing body language
___ Does not maintain hygiene and proper table manners

Motor Control Judgments

___ Has difficulty catching a ball
___ Has difficulty riding a bike
___ Has difficulty with fine motor skills

Sensory Overload

___ Gets carsick often
___ Exhibits hyperactivity
___ Exhibits hypersensitivity
___ Says "I can't" before trying
___ Throws unreasonable temper tantrums
___ Has frequent meltdowns
___ Hand flapping
___ Toe walking
___ Uses physical force to get point across
___ Has trouble recalling learned information

Spatial Judgments

___ Dislikes/avoids sports
___ Avoids doing puzzles
___ Stumbles into furniture
___ Exhibits poor sports performance

Visualization Judgments

___ Procrastinates often
___ Does not perform to his/her abilities in school
___ Fails to plan ahead on projects or life skills
___ Requires extra effort to perform simple tasks
___ Has trouble following through with directives
___ Has trouble reciting plot of movie or TV show
___ Has trouble comprehending simple directions
___ Has trouble understanding classroom material
___ Has difficulty in seeing another person's point of view
___ Fails to put items away after using them (coat, scissors, etc.)
___ Has trouble writing a complete grammatically-correct sentence