WHITBY VISION CARE

736 Dundas Street West, Whitby, Ontario L1N 2N4
reception@whitbyvision.ca • Tel: 905-666-4848 • Fax: 905-666-8160

CHILDREN HISTORY FORM

Child's Name _____ DOB (mm/dd/yy) _____ Age _____

Address _____ Health Card _____

City and Postal Code _____ Phone _____

Parent(s) Name(s) _____ Email _____

How you were referred to us _____

☐ I consent to receive electronic communications from Whitby Vision Care

MEDICAL HISTORY

Family Doctor _____ Allergies _____

Any Hospitalizations _____ Medications _____

Any history of…. *Please Indicate Who Had The Condition*

Self	Family		Self	Family		Self	Family	
☐	☐	Diabetes _____	☐	☐	Retinal Detachment _____	☐	☐	HIV/Hepatitis _____
☐	☐	Heart Problems _____	☐	☐	Thyroid Condition _____	☐	☐	Cancer _____
☐	☐	Stroke _____	☐	☐	Asthma/Allergies _____	☐	☐	Neuromuscular _____
☐	☐	Glaucoma _____	☐	☐	Colour Blindness _____	☐	☐	Macular Degeneration _____
☐	☐	High Blood Pressure _____	☐	☐	Arthritis _____			
☐	☐	Cataracts _____	☐	☐	Tuberculosis _____			

VISUAL HISTORY

Is this your child's first vision exam? Yes ☐ No ☐ If not, date of last examination _____

Any learning-related diagnosis? Yes ☐ No ☐ If yes, please list _____

Has a neurological and/or psychological evaluation been done? Yes ☐ No ☐ Please list _____

History of previous eye/vision problems, or treatment:

☐ Glasses	☐ Eye Turn/Strabismus	☐ Patching	☐ Medications/Drops	☐ Eye Injury
☐ Contact Lenses	☐ Lazy Eye/Amblyopia	☐ Surgery	☐ Vision Therapy	☐ Eye Shake/Nystagmus

Addition Info _____

_____

Visual Complaints

☐ Blurred Vision (far)	☐ Crossed, wandering eye	☐ Frequent headaches	☐ Difficulty tracking objects
☐ Blurred Vision (near)	☐ Squinting, excess blinking	☐ Tilts head	☐ Burning, itching, or tearing
☐ Double Vision	☐ Closes or covers one eye	☐ Eyestrain, fatigue	

☐ History of Concussion ☐ Participation in Competitive Sport Date of Last Concussion _____

Please See Reverse

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DEVELOPMENTAL HISTORY

Were there any complications during pregnancy or birth? Yes ☐ No ☐ Birth Weight _____

If yes, please describe _____

_____

Was the child born prematurely? Yes ☐ No ☐ If yes, how soon? _____

Age when child began… Sitting _____ Walking _____ Talking (2-3 word phrases) _____

Any speech problems now or in the past? Yes ☐ No ☐ Is your child clumsy? Yes ☐ No ☐

Any problems with fine motor coordination? Yes ☐ No ☐

Any other necessary information, please indicate _____

_____

ACADEMIC HISTORY

Current School & Teacher: _____ Grade: _____

Has your child repeated any grades? Yes ☐ No ☐ Which one? _____

Is your child receiving any tutoring/extra help/IEP/Resource Room? Yes ☐ No ☐ Please describe _____

_____

Academic Levels	Above Grade	On Grade	Below Grade	Special Help
Reading	☐	☐	☐	☐
Reading Comprehension	☐	☐	☐	☐
Spelling	☐	☐	☐	☐
Math	☐	☐	☐	☐
Handwriting	☐	☐	☐	☐

Does your child like to read? Yes ☐ No ☐

Academic Complaints

- ☐ Loss of place when reading
- ☐ Skipping words/lines when reading
- ☐ Words move/run together when reading
- ☐ Fatigue, falling asleep when reading
- ☐ Uses finger to read (after gr 2)
- ☐ Letter/number/word reversals
- ☐ Poor spelling
- ☐ Slow, inefficient reading
- ☐ Avoids reading
- ☐ Holds book too close
- ☐ Dislikes ball sports
- ☐ Misaligns numbers in a column
- ☐ Difficulty copying from the board
- ☐ Poor memory of what was read
- ☐ Poor Handwriting