PATIENT HISTORY QUESTIONNAIRE

Today's Date:_____

Dear Parents/Guardian:

Your child's vision develops along with such other functions as walking and talking and is affected by family history as well as by certain illnesses. Therefore, your thorough answers to this questionnaire will help in determining how your child's vision has developed as well as allowing us to use the office time for the complete optometric examination.

1. PERSONAL INFORMATION:

Child's Name: Last:_____ First:_____ MI:_____

Street Address: _____

City:_____ State:_____ Zip:_____

Home Phone No.:_____ Date of Birth:_____

Name of School:_____ Grade:_____

Mother's Name:_____ Father's Name:_____

Mother's Work No.:_____ Father's Work No.:_____

Mother's Cell No.:_____ Father's Cell No.:_____

Whom may we thank for referring you? :_____

[School / Doctor / Another Patient / Internet, etc.]

2. EYE HEALTH HISTORY:

Date of child's last eye exam?_____ Name of Doctor:_____

Has your child had any eye operations? Y/N Explain:_____Date:_____

Has your child had an eye injury? Y/N Explain:_____Date:_____

Has your child ever had vision therapy Y/N Explain:_____

Does your child wear glasses? Y/N If yes, circle all that apply: all the time – occasionally – reading – driving - TV

Describe any problems your child has with his/her glasses:_____

Please note, based on the scale below, if your child is suffering from any of the following signs or symptoms:

1 = never / 2 = seldom / 3 = occasionally / 4 = often / 5 = always

Physical Signs: Does your child…		**Performance Problems** Does your child…		**Secondary Symptoms** Does your child…	
report that the blackboard or other things look blurry?		have trouble copying words from the chalkboard to paper?		have a short attention span?	
get headaches after doing schoolwork?		avoid reading?		have poor self esteem or confidence in school?	
hold books extremely close?		lose his/her place when reading?		misbehave or "goof-off" in school?	
cover one eye by leaning on a hand?		skip or reread words and lines?		have frustration and anxiety associated with school?	
fall asleep when reading?		have difficulty completing schoolwork in a reasonable time?		seem to perform below his/her potential?	
report that words run together when reading?		have poor organization on paper- letter and word spacing, margins, columns		have inconsistent or poor sports performance?	
tend toward clumsiness?		reverse letters and numbers?		estimate distances incorrectly?	

3. DEVELOPMENTAL HISTORY:

Any complications before, during, or immediately following delivery*?* [prescription medication, infection, toxemia]

_____

_____

Full Term Pregnancy? Y/N If not, duration of the pregnancy _____
Child's birth weight? _____ pounds _____ ounces

At what age did your child?

Sit	_____	Months	Use sentences	_____	Years
Crawl	_____	Months	Toilet trained	_____	Years
Walk	_____	Months	Tied shoe laces	_____	Years
Talk	_____	Months (two or more words)			

Is your child's speech clear to others? Yes No
Does your child ride a two-wheeled bicycle without training wheels? Yes No

4. MEDICAL INFORMATION:

When was your child's last general health exam?_____

Name of pediatrician: _____ Phone No.: _____

List any medications your child is currently taking:_____

_____

List any eye drops your child is currently using:_____

Does your child have any allergies to medication? _____

Does your child have other allergies?_____

List any medical conditions your child is being treated for?_____

Has your child been hospitalized? Y/N Reason?_____

5. ACADEMIC HISTORY:

Circle Yes or No and explain if yes:

Does your child like school?	Y/N	_____
Is your child on grade level for reading?	Y/N	_____
Is your child on grade level for math?	Y/N	_____
Is your child in any special classes?	Y/N	_____
Is your child receiving any tutoring? If so, in what areas?	Y/N	_____

Is there any subject or are there any subjects which seem particularly easy for your child?

_____

Is there any subject or are there any subjects which seem particularly difficult for your child?

_____

Has your child ever undergone any of the following testing/treatment? Please indicate time periods.

Educational	Y/N	_____	Occupational Therapy	Y/N	_____
Neurological	Y/N	_____	Speech Therapy	Y/N	_____
Psychological	Y/N	_____	Physical Therapy	Y/N	_____
Developmental	Y/N	_____			

6. FAMILY HISTORY:

Please identify any family members next to the condition applicable:

Lazy Eye _____
Eye disease _____
Blindness _____
Nearsightedness _____
Farsightedness _____
Astigmatism _____

7. SUPPLEMENTAL INFORMATION:

Please use the space below to provide us with any additional information about your child which would further assist us during the evaluation. This may include, but is not limited to, any activities, hobbies, preferences, personality traits, or behavioral issues.

_____

_____

_____

_____

_____