Vision Care welcomes you to our office!

The following information is for our records. Please fill this form as completely as possible. If you have any questions, please ask a member of our staff for assistance.

Child's Name_____ Male _____ Female____

Parent(s) / Guardian (s) Names (s) _____

Name of School _____ Grade _____Grade Average _____

Name of Teacher_____

Birth History:

Was your child a full-term birth? If not, how many weeks early? _____

Were there any complications during the pregnancy? _____

Were there any complications with the birth or shortly after the birth?

_____

Developmental History:

Would you consider your child's development to be:

_____ above average _____ average _____ below average

At what age did your child first...

_____ crawl ----- walk _____ talk (4-6 word vocabulary)

School History

Have any grades been repeated? _____

Any problems with school work? _____

Have there been any changes in school performance in the past year? _____

What is your child's best subject? _____ Hardest subject? _____

Visual History

Does your child currently wear glasses or contact lenses? _____

If yes, when are they worn? _____

Does your child ever tilt his/her head to one side or close/cover one eye when reading?

_____

Does your child have difficult copying assignments from a book, the board or overhead projector? _____

Can your child read or write for what you consider to be an appropriate length of time?

_____

Does your child lose concentration after a short period of time when reading or doing any type of close work? _____

Does your child skip words, lines, or lose his/her place when reading or copying information from a book, the board or overhead projector? Does he/she use their finger to keep place? _____

Does your child ever mention that sometimes the print in a book looks "different" or "funny"? _____

Does your child squint or blink excessively when doing reading or writing tasks?

_____

Does your child write crookedly, have poor spacing, and/or does not stay on ruled lines?

_____

Does your child have difficulty completing board work on time?

_____

Patients's Name:_____ Age: _____ Date: _____

Questionnaire Completed By:_____

Check the column which best represents the occurrence of each symptom

	Never	Seldom	Occasional	Frequently	Always
Blur when looking at near					
Double Vision					
Headaches with near work					
Words run together when reading					
Burn , itch, watery eye					
Falls asleep reading					
Sees worse at the end of the day					
Skips / repeats lines reading					
Dizzy / nausea with near work					
Head tilt / close one eye when reading					
Difficulty copying from chalkboard					
Avoids near work / reading					
Omits small words when reading					
Writes up / down hill					
Misaligns digits / columns of numbers					
Reading comprehension down					
Poor / inconsistent in sports					
Holds reading to close					
Trouble keeping attention on reading					
Difficulty completing assignments on time					
Always says "I can't" before trying					
Avoids Sports/ games					
Poor hand / eye (poor handwriting)					
Does not judge distance accurately					
Clumsy, knocks things over					
Does not use his/her time well					
Does not make change well					
Loses belongings / things					
Car / motion sickness					
Forgetful / poor memory					