

Medical and Academic History

Please fill out this information regarding your child or teenager to the best of your ability.

Pediatrician: _____

Birth History

Problems during pregnancy	Yes	No
Problems during delivery	Yes	No

Baby born more than 2 wks early	Yes	No
Birth weight _____		

Medical History

My child is diagnosed with or has a history of:

Arthritis/ joint disease	Yes	No
Allergies	Yes	No
Asthma/ breathing problems	Yes	No
Heart problem	Yes	No
Anemia/Sickle Cell	Yes	No
Diabetes	Yes	No
Stomach problems	Yes	No
Headaches	Yes	No
Seizures	Yes	No
Developmental delay	Yes	No

(circle areas) *speech* *motor skills* *cognitive*

Other: _____

ADD/ADHD	Yes	No
Kidney disease	Yes	No
Other conditions: _____		

Medications and Allergies

List the medications or eye drops your child is taking:

List the medications to which your child is allergic:

Family History

The following conditions occur in my child's family (grandparents, parents, siblings):

Eye turn or Amblyopia (lazy eye)	Yes	No
Glasses before 6 years old	Yes	No
Blindness	Yes	No
Glaucoma	Yes	No
Macular Degeneration	Yes	No
Retinal Detachment	Yes	No
Diabetes	Yes	No
Heart disease	Yes	No
Other conditions: _____		

Ocular and Vision History

My child recently failed a vision screening. **Yes** **No**

My child wears glasses or contacts. **Yes** **No**

How frequently? _____

My child would like to wear contact lenses **Yes** **No**

My child has had eye surgery **Yes** **No**

Have you noticed any of the following:

Crossed or wandering eye **Yes** **No**

Frequent tearing or discharge **Yes** **No**

Red eyes **Yes** **No**

Excessive eye rubbing **Yes** **No**

White pupil **Yes** **No**

Drooping eyelid **Yes** **No**

Squinting **Yes** **No**

Does your child complain of the following:

Blurred vision **Yes** **No**

Eye strain/tired eyes **Yes** **No**

Frequent headaches **Yes** **No**

Seeing double **Yes** **No**

Loss of place when reading **Yes** **No**

Words moving on the page **Yes** **No**

Last Eye Examination: _____

Where? _____

School History

Current grade _____ [] not school age

Classroom: **Typical** **Special Needs** **Homeschool**

My child:

Reads on grade level **Yes** **No**

Is on grade level in math **Yes** **No**

Has a learning disorder/dyslexia **Yes** **No**

Reverses letters or numbers **Yes** **No**

Has an Individual Education Plan (also known as IEP)? **Yes** **No**

Receives the following therapy (circle type)
speech occupational physical

Other concerns: _____
