**PEDIATRIC HISTORY FORM**

Please fill out this questionnaire carefully and completely. You may fax it to: 970-927-5108 or return it to our office before your child’s scheduled appointment. This will allow us to spend the most quality time with your child.

Date: Click here to enter date

**GENERAL INFORMATION**

Child’s Full Name: Click here to enter name. Nickname: Click here
Male [ ]  Female [ ]  Date of Birth: Click here to enter a date.
Mother’s Name: Click here to enter name. Father’s Name: Click here to enter name.
Address: Click here to enter address. City: Click here to enter. State: Click here Zip: Click here
Home Phone: Click here. Cell Phone: Click here. Work Phone: Click here.
Parent/Guardian Name: Click here.
Child resides with: Click here to enter. At address: Click here to enter.
Name of School: Click here to enter. Grade: Click here.
Referred by: Click here to enter.

**PRESENT SITUATION**
Why do you wish your child to be evaluated? Click here to enter text.

List any complaints your child makes concerning his/her vision: Click here to enter text.

At what age did this problem begin? Click here
Under what circumstances did the problem begin? Click here to enter text.

Has the problem become better? [ ]  Or worse? [ ]  Explain: Click here to enter text.

Does anyone else in the family have a similar problem? Click here to enter text.

Have you attempted to correct the problem at home? Yes [ ]  No [ ]  How? Click here to enter text.
What were the results? Click here to enter text.
Has there been previous treatment? Click here to enter text.
Does the child feel that she or he has a problem? Yes [ ]  No [ ]
 If yes, what is the child’s attitude toward the problem? Click here to enter text.

Have you or your child noticed any of the following? (while wearing their glasses/contacts if prescribed)
Please check symptoms which occur frequently with 2 checks and those that occur occasionally with 1 check.

**SYMPTOMS AND OBSERVATIONS**

[ ] [ ]  Unusual blinking or eye rubbing [ ] [ ]  Headaches
[ ] [ ]  Watering or bloodshot eyes [ ] [ ]  Blurred vision distance or near
[ ] [ ]  Red-rimmed, crusted or swollen lids [ ] [ ]  Double vision
[ ] [ ]  Eyelid twitch or muscle spasm [ ] [ ]  Dizziness
[ ] [ ]  Squint, close or cover one eye [ ] [ ]  Carsickness
[ ] [ ]  Difficulty tracking moving objects, balls etc [ ] [ ]  Eyes hurt or tired after close work
[ ] [ ]  Short attention span [ ] [ ]  Head too close to paper when reading/writing
[ ] [ ]  Make errors copying [ ] [ ]  Unusual posture/head tilt when reading/writing
[ ] [ ]  Writing is crooked or poorly spaced [ ] [ ]  Frequent head turning while reading
[ ] [ ]  Poor spelling [ ] [ ]  Skip lines or lose place while reading or copying
[ ] [ ]  Confuse right and left direction [ ] [ ]  Reread or omit words

**SYMPTOMS AND OBSERVATIONS**

[ ] [ ]  Confuse or reverse letters, numbers or words [ ] [ ]  Print “runs together” or words “jump”
[ ] [ ]  Fatigue easily [ ] [ ]  Print comes in and out of focus
[ ] [ ]  Avoid near tasks such as reading [ ] [ ]  Poor reading comprehension
[ ] [ ]  Eyes bothered by light [ ] [ ]  Eye turns in or out

**SCHOOL HISTORY**

Age at time of entrance to: Kindergarten Click here First Click here
Does she or he like school? Yes[ ]  No[ ]  Teacher? Yes[ ]  No[ ]
School work is: Above average [ ]  Average[ ]  Below Average [ ]
Do you feel she or he is working up to potential? Yes [ ]  No [ ]
Specifically describe any school difficulties: Click here to enter text.
What subjects are easy for your child? Click here to enter text.
What subjects are difficult for your child? Click here to enter text.
Possible reasons for difficulties: Click here to enter text.
Has a grade been repeated? Yes[ ]  No[ ]  Which grade? Click here
Does she or he attend any special classes? Yes [ ]  No [ ]  If yes, explain: Click here to enter text.
Has attendance been regular? Yes [ ]  No [ ]  If no, explain: Click here to enter text.
Does she or he like to read? Yes [ ]  No [ ]  Voluntarily? Yes [ ]  No [ ]  What do they like to read? Click here to enter text.
Does your child prefer to read to rather than reading on their own? Read to [ ]  Reads on own [ ]
\*\* Please arrange to bring a copy of special school testing if any has been completed.

**GENERAL BEHAVIOR**

Does she or he actively participate in play, sports, or athletics? Yes [ ]  No [ ]  Which ones?Click here to enter text.
Does she or he enjoy music? Yes [ ]  No [ ]  Can she or he carry a tune? Yes [ ]  No [ ]  Keep rhythm? Yes [ ]  No [ ]
Are there any behavior problems? Click here to enter text.
What causes these problems? Click here to enter text.
Child’s reaction to fatigue: Sags [ ]  Irritable [ ]  Other Click here to enter text.
Child’s reaction to tension: Nail biting [ ]  Thumb sucking [ ]  Other: Click here to enter text.

**MEDICAL HISTORY**

List illness, bad falls, high fever, etc: Please list the illness/injury, age, mild/severe and any complications
Illness/injury: Click here to enter text.
List any medications or over-the-counter drugs taken at the present time.
Name of medication and reason: Click here to enter text.
Health at present: Excellent [ ]  Good [ ]  Fair [ ]  Poor [ ]
Are there any chronic problems like asthma, hay fever, cold, allergies or ear infections? Click here to enter text.
When was the last vision examination? Click here Dr.?Click here
Were glasses prescribed? Yes [ ]  No [ ]  Were recommendations made? Yes [ ]  No [ ]  If yes, explain:Click here
Was the treatment program followed? Yes [ ]  No [ ]  Was the treatment effective? Yes [ ]  No [ ]
Has a program of vision therapy been recommended? Yes [ ]  No [ ]  Completed? Yes [ ]  No [ ]
Members of the family who have had visual attention and why?
Name:Click here Age: Click here Visual Condition/Treatment: Click here to enter text.
Name:Click here Age: Click here Visual Condition/Treatment: Click here to enter text.
Are there indications of hearing or speech related problems? Yes [ ]  No [ ]  If yes, explain: Click here to enter text.

Has a neurological, psychological, educational, visual, speech or hearing evaluation been performed? Yes [ ]  No [ ]
Type of Evaluation? Click here to enter text. By whom? Click here to enter text. Diagnosis: Click here to enter text.
Type of Evaluation? Click here to enter text. By whom? Click here to enter text. Diagnosis: Click here to enter text.

**DEVELOPMENTAL HISTORY**

List any drugs, medications or complications during pregnancy: Click here to enter text.
Length of pregnancy: Click here Normal Birth? Yes [ ]  No [ ]  If no, please explain: Click here to enter
Complications before [ ]  during [ ]  or following [ ]  delivery?
Did your child crawl (stomach on floor)? Yes [ ]  No [ ]  Age Click here On hands and knees? Yes [ ]  No [ ]  Age Click here
Was there anything unusual about crawling or early motor development? Click here to enter text.
At what age did your child walk? Click here
Did arms or legs require special braces? Arms Yes [ ]  No [ ]  Legs Yes [ ]  No [ ]
Can most children his or her age run faster? Yes [ ]  No [ ]  Throw or catch a ball better? Yes [ ]  No [ ]
Which hand does your child use for eating? R [ ]  L [ ]  Writing? R [ ]  L [ ]  Throwing? R [ ]  L [ ]
Has she or he always used the same hand? Yes [ ]  No [ ]  Was any guidance given? Yes [ ]  No [ ]
Which foot does she or he use for kicking? R [ ]  L [ ]  Hopping? R [ ]  L [ ]
Your child’s first words were at age: Click Was early speech clear to others? Yes [ ]  No [ ]  Is it clear now? Yes [ ]  No [ ]

**HOME ENVIRONMENT**

Does anyone else live in the home? Yes [ ]  No [ ]  If yes, give ages and relationship to child Click here to enter text.
Additional home information ( frequent moving, separation, divorce, death, remarriage of one parent etc
Click here to enter text.

Previous nursery or other group experiences (Sunday School, camp, etc) Click here to enter text.

**INTERESTS AND ABILITIES**

Does she or he have any special abilities? (art, music, etc) Click here to enter text.
Favorite activities – What does your child find most rewarding? Click here to enter text.
Give a brief description of your child’s personality: Click here to enter text.

Thank you