**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