PATIENT HISTORY FORM

Please fill out this questionnaire carefully and bring it to our office for your child's scheduled appointment.
If patient is an adult, please skip questions that do not apply. Page 4 is to be completed with your child.

GENERAL INFORMATION

Patient Name_____ Nickname_____
Age_____Date of Birth_____
Mother's Name_____Father's Name_____
Guardian's Name(s)_____
Child resides with_____at _____
Name of School_____Grade_____
Referred By_____

Present Situation
What prompted you to schedule this evaluation?_____
_____
_____
List any current vision problems/concerns:_____
_____
_____
At what age did this problem begin?_____
_____
Has the problem become better or worse?_____Explain_____
_____
_____
Does any one else in the family have a similar problem?_____
_____
Has there been previous treatment?_____
_____
Does the patient feel that he or she has a problem?_____
_____

Have you or your child noticed any of the following symptoms while reading, working on the computer or doing paperwork?
Please mark symptoms which occur frequently with <u>two</u> checks and those which occur occasionally with <u>one</u> check.

SYMPTOMS AND OBSERVATIONS

__ Losing place
__ Skipping lines
__ Using finger as a pointer
__ Loss of comprehension
__ Excessive movement/squirming/hyperactivity
__ Misaligning numbers or digits in a column
__ Changing beginnings or ending of words
__ Skipping or missing small words
__ Re-reads lines unknowingly
__ Squinting or frowning
__ Closing or covering one eye
__ Excessive head tilt
__ Trouble copying from chalkboard to paper
__ Trouble copying from book to notebook
__ Slow, laborious reading
__ Avoidance of close work
__ Short attention span
__ Must re-read to obtain meaning
__ Distance blur after reading or paperwork

__ Blurring of print
__ Doubling of print
__ Print moving around
__ Reversals
__ Watery eyes
__ Eyestrain
__ Eye fatigue
__ Burning of eyes
__ Headaches
__ Nausea
__ Dizziness
__ Excessive blinking
__ Rubbing eyes
__ General discomfort
__ Tired eyes
__ Bloodshot eyes
__ Sleepiness
__ Frustration
__ Fatigues easily
__ Frequent styes

EDUCATIONAL HISTORY

Have your or your child been diagnosed with: ☐ ADD/ADHD ☐ Dyslexia ☐ Learning Disability
If not, do you or your child feel a learning disability is present? Yes_____No_____
What subjects are easy for you or your child?_____
What subjects are difficult for you or your child?_____
Specifically describe any difficulties with learning:_____
_____
Do you or your child like to read?_____
Does your child prefer to be read to rather than reading on his or her own?_____
Age at time of entrance to: Kindergarden_____First_____
Does he or she like school? Yes_____No_____Teacher? Yes_____No_____
School work is: Above Average_____Average_____Below Average_____
Do you feel he or she is working up to potential?_____
Has a grade been repeated? Yes_____No_____Which_____
Does he or she attend any special classes? Yes_____No_____If yes, explain_____
_____
Has attendance been regular? Yes_____No_____If no, explain_____
_____
Please arrange to bring a copy of special school testing if any has been completed.

MEDICAL HISTORY

List illness, bad falls, high fever, etc.:

Illness/Injury	Age	Mild/Severe	Complications (if any)

List any medication or over-the-counter drugs taken at the present time: (name of medication and reason) _____
_____
Health at present: Excellent_____Good_____Fair_____Poor_____
Are there any chronic problems like asthma, hay fever, cold, allergies, or ear infections?_____
_____
When was the last vision examination?_____Dr._____
Were glasses prescribed?_____Were recommendations made?_____If yes, explain: _____
_____
Was the treatment program followed?_____
Was the treatment effective?_____
Has a program of vision therapy been recommended?_____Completed?_____
Members of the family who have had visual attention and why?

Name	Age	Visual Condition/Treatment

Are there indications of hearing or speech related problems?_____Explain_____
_____

Has a neurological, psychological, educational, visual, speech or hearing evaluation been performed?

Type of Evaluation	By Whom	Diagnosis

DEVELOPMENTAL HISTORY

List any drugs, medications or complications during pregnancy:_____
_____
Length of pregnancy:_____Normal Birth?_____ APGAR: 1 min:_____5 min:_____
Complications before, during, or following delivery?_____
Did your child crawl (stomach on floor)?_____Age_____(on hands and knees)?_____Age_____
Was there anything unusual about crawling or early motor development?_____
At what age did your child walk?_____
Did arms or legs require special braces?_____
Can most children his or her age run faster?_____Throw or catch a ball better?_____
Which hand does your child use for eating?_____Writing_____Throwing_____
Has he or she always used the same hand?_____Was any guidance given?_____
Which foot does he or she use for kicking?_____Hopping_____
Your child's first words were at age:_____Was early speech clear to others?_____Is it clear now? _____

GENERAL BEHAVIOR

Do you or your child participate in sports, or athletics?_____Which ones?_____
Are you or your child as efficient as you want to be at sports? Yes_____ No_____If no, give example:_____
_____
Does your child actively participate in play? Yes_____ No_____If no, what do you think is the cause?_____
_____
Are there any behavior problems?_____
What triggers these problems?_____

During sports or physical activity, do you or your child experience:

__ Difficulty catching a ball
__ Difficulty throwing a ball
__ Missing hitting the ball
__ Awkwardness or clumsiness
__ Difficulty following a moving target
__ Poor depth perception
__ Action happening too fast
__ Losing your orientation
__ Motion sickness

INTERESTS AND ABILITIES

List any special abilities? (art, music, etc.)_____
_____
Favorite activities--what do you or your child find most rewarding?_____
_____
Give a brief personality profile:_____
_____
_____
_____

What would you like to see your child achieve? Please list some specific goals for your child:
1._____
_____
2._____
_____
3._____
_____
4._____
_____

Ask your child if they experience any of the following symptoms
when they read:

- ☐ Words look fuzzy or blurry
- ☐ Letters or words double
- ☐ Words move around
- ☐ Eyes feel tired
- ☐ Eyes burn
- ☐ Headache
- ☐ Feel dizzy
- ☐ Feel nauseous
- ☐ Have a stomach ache
- ☐ Get sleepy

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