Palos Verdes Family Vision Optometry

Developmental History

This history questionnaire is given to you for completion serves several purposes. It allows us to plan in advance for the tests and examination routines which will best apply to your child's condition and gives the doctor more time to spend with your child.

Child's Full Name: _____ **Date of Birth:** _____ **Date:** _____

Name & Address of School: _____

Grade: _____ Teacher: _____ School Nurse: _____ Pediatrician: _____

Referred by _____

PRESENT SITUATION:

Why do you feel your child needs a visual examination? _____

_____

Is there any evidence from the school or psychological tests that some visual difficulties may be present? ☐ Yes ☐ No

If so, what? _____

Does your child report any of the following:

Headaches	☐ Yes	☐ No	When: _____
Blurred Vision	☐ Yes	☐ No	When: _____
Double Vision	☐ Yes	☐ No	When: _____
Eyes "hurt" or "tired"	☐ Yes	☐ No	When: _____

List any other complaints your child has concerning his/her vision: _____

_____

VISUAL BEHAVIOR:

Have you or anyone else ever noted the following:	Yes	No	If so, when?
Holding reading or writing materials too close	☐	☐	_____
Closing or covering one eye	☐	☐	_____
Eyes frequently reddening	☐	☐	_____
Frequent eye rubbing	☐	☐	_____
Excessive blinking	☐	☐	_____
Frequent styes	☐	☐	_____
Tilting head when reading or writing	☐	☐	_____
Moves head when reading	☐	☐	_____
Uses finger as a marker	☐	☐	_____
Confuses letters or words	☐	☐	_____
Reverses letters or words	☐	☐	_____
Skips, rereads or omits words or lines	☐	☐	_____
Vocalizes when reading silently	☐	☐	_____
Reads slowly	☐	☐	_____
Poor reading comprehension	☐	☐	_____
Tires easily/Short attention span	☐	☐	_____
Poor penmanship	☐	☐	_____
Poor general coordination	☐	☐	_____
Bothered by light	☐	☐	_____
Inability to see distant objects	☐	☐	_____

VISUAL HISTORY:

Date of last vision examination: _____ Reason: _____

Doctor's Name: _____

Were glasses prescribed? ☐ Yes ☐ No Are they worn? ☐ Yes ☐ No When? _____

Family vision conditions: Mother _____ Father _____ Siblings _____

Has your child ever received vision therapy? ☐ Yes ☐ No When? _____

Results: _____

_____

GENERAL BEHAVIOR:

Are there any behavior problems? School: ☐ Yes ☐ No Home: ☐ Yes ☐ No

Please describe: _____

To what do you attribute these problems? _____

SCHOOL:

Age entering kindergarten: _____ First grade: _____

Does your child like school? ☐ Yes ☐ No Teacher? ☐ Yes ☐ No

Do you feel he/she is working up to potential? ☐ Yes ☐ No

Specifically describe any school difficulties: _____

Child's academic performance:	Above Average	Average	Below Average
Reading	☐	☐	☐
Math	☐	☐	☐
Spelling	☐	☐	☐
Writing	☐	☐	☐

Has a grade been repeated? ☐ Yes ☐ No Which: _____

Does he/she seem to be under tension or extreme pressure when doing school work? ☐ Yes ☐ No

Has he/she had any special tutoring and/or remedial assistance? ☐ Yes ☐ No

When: _____ From whom: _____ Where: _____ How long: _____

Results: _____

DEVELOPMENTAL HISTORY:

Full term pregnancy? ☐ Yes ☐ No Normal birth? ☐ Yes ☐ No

Any complications before or after delivery? ☐ Yes ☐ No If so, what? _____

Did your child crawl? ☐ Yes ☐ No All fours? ☐ Yes ☐ No Age: _____

At what age did your child walk? _____ Speak? _____

As an infant was your child active? ☐ Yes ☐ No Now? ☐ Yes ☐ No

List any severe illness your child has had: _____

FAMILY AND HEALTH HISTORY:

Briefly describe child's physical condition: _____

List any medications your child is currently using: _____

For what condition: _____

Did parents or any other the other children in the family have learning problems? ☐ Yes ☐ No

Who: _____ To what extent: _____

NUTRITION:

Please give a brief description of the nutritional philosophy in the child's home: _____

PERSONALITY:

Please give a brief description of your child's personality: _____

As you complete this form you will recognize the thoroughness with which your child's visual problems will be considered. Your child's future deserves the fullest consideration that you as a parent and we here in the office can provide.

It is often beneficial for us to discuss examination results with your child's school and/or other professionals involved in his/her care. Please sign below to authorize this exchange of information.

Signature: _____ Date: _____ Relation to child: _____