Child's Name____Date____________
Date of Birth:_____________________________________ Age _________ Grade _________

RESPONSIBLE PERSON INFORMATION:

Name____ Relationship ___________________
Home Address:____ City/State:____________ Zip:______
Preferred Phone__________________________________ Email:______________________________
Has your child had a previous visual evaluation? Yes □ No □
Doctor's Name: _______________________ Date of Last Visit:________________________
Results and recommendations:____
Were glasses, contact lenses, or other optical devices ever prescribed? Yes □ No □
If yes: Bifocal: □ Single-vision: □ Contact lenses: □ Other: □ Explain: ______
Are they used? Yes □ No □
If yes, when are they worn? □ for distance only □ for near only □ wears them full time □ other ____
If no, why not?____
Has your child ever had vision therapy? □ Yes □ No If yes, for what condition? ____________________
Has your child been diagnosed with a "lazy eye" or amblyopia? □ Yes □ No
If yes, was patching prescribed? □ Yes □ No How often is it being done? _________________
Has your child been diagnosed with or do you notice your child's eye turn ? □ Yes □ No
If yes, please fill out or request Child Strabismus History Form

What is your main reason for coming here today?______________________________________
____

Have you noticed any unusual signs or symptoms that concern you?_____________________
____

Has your child's ability to do any activity been restricted because of vision? Please explain____

HEALTH HISTORY: Check any conditions that apply to your child or that run in your family.

Eye surgery □ Child □ Family
Color "blind" □ Child □ Family
Light sensitive □ Child □ Family
Dry eyes □ Child □ Family
Floaters/spots □ Child □ Family
Flashing lights □ Child □ Family
Retinal detachment □ Child □ Family
Cataracts □ Child □ Family
Glaucoma □ Child □ Family
Blindness □ Child □ Family
Cancer □ Child □ Family
Diabetes □ Child □ Family
Respiratory disease □ Child □ Family
Heart problem □ Child □ Family
High blood pressure □ Child □ Family
Thyroid □ Child □ Family
Migraine or headaches □ Child □ Family
Neurological conditions □ Child □ Family
Psychiatric conditions □ Child □ Family
Hematological conditions □ Child □ Family

Please indicate any other medical or ocular conditions your child has been diagnosed or being treated for:
____
Is your child currently under a physician's care? □ Yes □ No
Why?________________________________
Is your child regularly taking pills or medications? □ Yes □ No Specify ____________________________
Does your child have any allergies? Please specify ____
Date of child's last physical______________ How is child's general health?________________________
Has your child had any history of head trauma, head injury, or concussion ? □ Yes □ No
If yes, date of incident ________ description of incident __________________________________

School-Related Vision Problems:

Have any of your children had difficulty in school? □ Yes □ No

Please explain____

How do you feel your child is doing in school? □ Well □ Below potential □ Poorly

Please check the signs and symptoms that best describe how your child is doing in school

□ Does your child squint when looking up from reading?
□ Have trouble seeing the chalkboard?
□ Frequently blink or rub eyes?
□ Complain of headaches while reading or after doing school work
□ Complain of eye strain or pulling sensation around the eyes while reading or doing school work
□ Shows poor general motor coordination skills? Frequently awkward, bump into things, knock things over?
□ Hold books extremely close?
□ Report that things look blurry?
□ Reports that things look double?
□ Have trouble copying work from the chalkboard to paper?
□ Spends a long time doing homework that should take only a few minutes?
□ Reduced attention span, can concentrate for only a moderate time?
□ Covers one eye to see better ?
□ Lays head on desk when doing pencil work?
□ Frequently loses place when reading?
□ Skips or re-reads words and lines?
□ Reverses words or letters (was for saw, b for d) beyond second grade?
□ Does better at math than English, history or social studies?
□ Must re-read material several times to grasp its meaning?
□ Gets tired quickly when doing reading or homework?
□ Short attention span? Can concentrate on reading work for only a few minutes.
□ Daydreams a lot? Stares off into the distance frequently?
□ Learns best through auditory tactics (listens to learn)?
□ Avoids work that includes reading or near seeing?
□ Is more than 1 year behind in reading-related skills?
□ Has poor posture? Slouches, slumps in chair?
□ Has difficulties with eye- hand coordination activities ?
□ Difficulty with depth perception or hitting/ catching a ball?
□ Gets overwhelmed in visually crowded environments or performing a task with lots of visual information

SCHOOL SERVICES:
Please check off any services your child is receiving through school or privately:

❑ Individualized Education Plan (IEP) ❑ Special tutoring in subject(s)
____

❑ Speech Therapy ❑ Occupational Therapy ❑ Physical Therapy ____days per week □ school □ private

DEVELOPMENTAL MILESTONES:
Full Term Pregnancy? □ Yes □ No Normal Birth? □ Yes □ No
Any complications before, during or immediately following delivery? □ Yes □ No
Please describe____
At what age did your child crawl? _____
At what age did your child walk? ______ Is your child active? □ Yes □ No
Speech: First words at age____ Is your child's speech clear now? □ Yes □ No

RECREATION AND LEISURE: In what recreational activities does your child participate? (Circle)
Read, baseball, basketball, soccer, swim, build models, sew, dance, perform, play an instrument.

Other recreational or sports activities?____
Does your child wear protective eyewear for his/her sport? □Yes □No

Does your child watch much television? □ Yes □ No Number of hours daily___________

Does your child use a computer at home? □ Yes □ No Number of hours daily___________

Does your child use a computer at school? □ Yes □ No Number of hours daily___________

Does child often play video games? □ Yes □ No Number of hours daily___________

Does he/she play hand-held video games? □ Yes □ No Screen type □ Bright □ Dim

REFERRAL INFORMATION:

How were you referred to our office?
❑ Another Doctor or Therapist ❑ School ❑ Relative ❑ Friend ❑Insurance ❑Online Search ❑Website

If you were referred by another doctor or therapist please fill out with any information you have:

Practitioner name: ______________________________Specialty_______________________________
Office or School name______________________Phone ___________________ Fax _______________
Email ______________________Address _________________ City/ State _________ Zip___________
Are you currently undergoing treatment by this physician or therapist? ❑ Yes ❑ No
If yes, for what conditions?_______________________ How many times per week/month?_________

RELEASE OF INFORMATION:
It is often beneficial to us to discuss examination results and to exchange information with your child's school, pediatrician, and/or other professionals involved in his/her care. Please sign below to authorize this exchange of information.
I agree to permit information from, or copies of, my child's examination records to be forwarded to other health care providers or insurance carriers upon their written request or upon the recommendation of the MIDTOWN VISION DEVELOPMENT CENTER when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I authorize MIDTOWN VISION DEVELOPMENT to exchange information with my child's school and other professionals involved in my child's care by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

Parent's or Guardian's Signature____ Date______________