

**FAMILY VISION CARE - Dr. Gary Sneag and Dr. Jennifer N. Tam
CHILD HISTORY FORM**

Child's name: _____ Male ___ Female ___ Birthday: ___ / ___ / ___ Age: ___ yr ___ mo
 Address: _____ Phone #: _____
 Parent's name: _____ Occupation: _____ Parent's Work #: _____
 Parent's name: _____ Occupation: _____ Parent's Work #: _____
 School: _____ Grade: _____ Teacher's name: _____
 Sibling(s) name and age: _____
 Do you have major medical insurance? If yes, name of carrier: _____
 Policy #: _____ Social Security Number: _____ -- _____ -- _____

I. What is the main reason for this examination? _____

II. Symptoms:

Vision:	Yes	No	School:	Yes	No
Blurred distance vision			Is your child having problems in school?		
Blurred reading vision			Does your child like the teacher?		
Headaches/dizziness			Are you satisfied with child's performance?		
Skips words/loses place while reading			Is the school satisfied with child's performance?		
Eye strain or tire			Do grades reflect his or her ability?		
Eyes hurt			Uses finger to read		
Lazy eye/amblyopia			Easily distracted		
Eye turn (in or out)			Poor self esteem		
Covers one eye with near work			Trouble completing written assignments		
Holds reading too close			Difficulty copying from the board		
Jerky eye movements			Easily fatigued while reading		
Double vision			Easily frustrated		
Squinting, eye rubbing or blinking			Reversals of numbers/letters		
Red, irritated or itchy eyes			Can your child sit still for long periods?		

III. Medical and Visual History: Please check those that apply to your child or that run in your family.

- | | | | | | |
|-----------------------|-------------------------------|---------------------------------|-----------------------|-------------------------------|---------------------------------|
| Allergies | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Lazy eye | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Respiratory disease | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Turned eye | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Diabetes | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Color "blind" | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Drug sensitive | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Light sensitive | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Elevated cholesterol | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Eyestrain | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Heart problem | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Dry eyes | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| High blood pressure | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Floaters/spots | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Thyroid | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Flashing lights | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Migraine or headaches | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Macular Degeneration | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Seizures | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Retinal detachment | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Head trauma | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Cataracts | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Ear Infections | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Glaucoma | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Learning difficulties | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Eye surgery or injury | _____ | |

Last visual eye exam date: _____ Were eyeglasses/contact lenses prescribed? _____
 Are they worn constantly or for specific tasks? _____

Physician/Pediatrician: _____ Address: _____
 Date of last visit: _____ Current concerns: _____
 List all medications currently taken by child: _____
 Please list any other medical problems: _____
 Please list any allergies: _____

IV. Birth and Developmental History:

Describe mother's health during pregnancy: _____
Did the mother use any substances or medication (e.g. alcohol) during pregnancy? _____

Describe the delivery: Normal Breech Caesarian Forceps Induced

Was the child premature? _____ If so, how early? _____

Child's birth weight: _____ Apgar score at birth: _____

Were there any complications before, during, or after delivery? No ___ Yes ___ If yes, please describe:

Does your child have any congenital problems such as heart, lung, or birth defects? _____

Describe any health problems during infancy: _____

Circle any problems your child had during his/her first year:

- | | | | |
|---------------|-------------------------|------------------|------------------|
| Allergy | Poor sucking/swallowing | Colic | Sleep problems |
| Hyperactivity | Underactivity | Feeding problems | Excessive crying |

At what age in years and months did your child: Start to crawl _____ Walk unaided _____

Speak words clearly _____ Tie their shoes _____ Button their coat _____

V. General Behavior:

Are there any behavioral problems at school? If yes, please describe: _____

Are there any behavioral problems at home? If yes, please describe: _____

Does your child say and/or do things impulsively? _____

VI. Therapy/Educational Evaluation:

Has your child ever had a neurological, psychological, and/or occupational therapy evaluation? No__ Yes__

If yes, by whom? Results and recommendations: _____

Has there been any previous therapy for learning difficulties, visual or speech problems? No ___ Yes ___

If yes, please state type of therapy, duration and results: _____

VERY IMPORTANT! Who may we thank for referring you to our office?

Name of friend or relative: _____

If not referred, how did you choose our office for your visual needs? Please circle the appropriate answer:

- Saw the office -- School screening -- Yellow Pages -- Insurance -- Health Fair -- Website

-- Other: _____

Signature of responsible party _____ Date: _____

Insurance Disclaimer: I understand I am financially responsible, whether my insurance company pays or not, for all charges incurred by me. I further agree that in the event of nonpayment, I will bear the cost of collection and/or court costs and reasonable legal fees should such court action be required. I agree that a photocopy of this authorization shall be valid as the original.