Child's Additional History
(Ages 0-18)

If the patient is 18 years or younger, please provide the following information in addition to the medical and vision history form.

Child's Name _____ **Date** _____

Have you noticed any unusual signs/symptoms that concern you? Yes No

If yes, please explain: _____

Has your child's ability to do any activity been restricted because of vision? Yes No

If yes, please explain: _____

When was your child's last physical? _____

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

Please explain any difficulties in school: _____

Health History and Developmental Milestones:

Full term Pregnancy? Yes No Normal Birth? Yes No Complications with birth? Yes No

If complications, please explain: _____

Any serious/major falls, injuries, or illnesses? Yes No

Explain: _____

Motor:

Did your child creep (stomach on floor)? Yes No At what age? _____

Did your child crawl (stomach off floor)? Yes No At what age? _____

Did your child move around on all fours? Yes No At what age? _____

At what age did your child walk? _____ Was your child active? Yes No

Speech:

First words at what age? _____ Was speech clear to others? Yes No Is speech clear now? Yes No

Recreation and Leisure:

Please list any recreational/sport activities your child participates in:

_____

Does your child wear protective eyewear for his/her sport? Yes No

How much television does your child watch a day? _____

How much time does your child use a computer at home? _____

How much time does your child use a computer at school? _____

How much time does your child play video games (tv or handheld)? _____

How much does your child read for fun? _____

Continued on reverse

Symptoms:

Your child can have "20/20" eyesight and still have vision problems that can affect their learning and classroom performance. Listed below are many signs and symptoms of learning-related vision disorders. Please answer, to the best of your knowledge, how often the following symptoms are occurring:

Symptoms	Never	Seldom	Occasional	Frequently	Always
Blurred vision at near					
Double vision					
Short attention span					
Falls asleep when reading					
Burning/stinging/water eyes/rubs eyes					
Headaches with near work					
Vision worse at the end of the day					
Saying "I can't" before trying					
Dizziness or nausea with near work					
Knocks things over					
Forgetful/Poor memory					
Awkward/bumps into things					
Avoidance of reading/near work					
Omitting small words when reading					
Squints when looks up from reading					
Rather be read to than self reading					
Reading comprehension declines over time					
Holds reading material too close					
Words run together when reading					
Aggressive with other kids					
Skips or repeats lines when reading					
Head tilt or closes one eye when reading					
Reverses letters or words					
Rereads to understand					
Car/motion sickness					
Homework takes longer than it should					
Acts up when asked to do school work					
Tires quickly with near work or reading					
Difficulty with money concepts or making change					
Misaligning digits in columns or numbers					
Difficulty with board copy					
Poor posture					
Writes uphill or downhill					
Difficulty with time management					
Misplaces items					
Difficulty with hand tools/scissors/pencil					
Moody or depressed about school					
Inconsistent/poor sports performance					
Avoids sports and games					
Daydreams					