WELCOME TO OUR OFFICE

Child's full name_____DOB_____ Age Now_____
Address_____City_____Postal Code_____

Father's name_____Cell phone_____
Occupation_____ Email_____

Mother's name___Cell phone _____
Occupation_____ Email_____

Name of School_____Grade_____
Address_____
Teacher's Name _____

Referred by _____
Reason for referral_____

What do you expect to find out from the exam _____

Physician_____Last medical exam _____

Present medications_____ Allergies_____

Please check the conditions that apply to your child or that run in your family:
Ocular Disease/Condition

	Yes	No	Relationship		Yes	No	Relationship
Lazy eye	☐	☐	_____	Turned eye	☐	☐	_____
Retinal detachment	☐	☐	_____	Macular Degeneration	☐	☐	_____
Colour blind/deficiency	☐	☐	_____	Glaucoma	☐	☐	_____
Light Sensitive	☐	☐	_____	Eye Surgery_____	☐	☐	_____

Developmental History

Is the child adopted? ____ If yes, does the child know? _____ Age when adopted _____
Full term pregnancy?_____Normal birth?_____
Any complications before, during, or following delivery?_____
Was the child exposed in utero to: □drugs □alcohol □nicotine
Did your child crawl? □Yes □No Age_____ Age at which child walked?_____
Age of speech: First words?_____Sentences?_____
When fatigued, child will: Sag_____Becomes irritable_____excited_____
Under tension, is there any pattern of behavior, thumb-sucking, etc? _____
_____

PLEASE TURN OVER TO COMPLETE

PRESENT SITUATION: In what ways does your child seem to have difficulty? How does your child complain about his or her vision?

_____

_____

Has anyone noticed an eye turn in or wander out? □ Yes □ No Which eye?_____When? _____

Does your child ever report any of the following, and if yes, when?

Headaches	□Yes	□No When _____	Eyes hurt or tired	□Yes	□No When _____
Blurred Vision Far	□Yes	□No When _____	Double Vision	□Yes	□No When _____
Blurred at Near	□Yes	□No When _____	Light sensitivity	□Yes	□No When _____

Have you ever noticed the following?

Holding reading close	□Yes	□No When_____	Distorted posture when reading?	□Yes	□No When_____
Holding reading further away	□Yes	□No When_____	Inability to see distance objects?	□Yes	□No When_____
Closing one eye?	□Yes	□No When_____	Bumping into objects?	□Yes	□No When_____
Covering one eye?	□Yes	□No When_____	Poor general coordination?	□Yes	□No When_____
Eyes frequently reddened?	□Yes	□No When_____	Skips words or rereads	□Yes	□No When_____
Frequent styes?	□Yes	□No When_____	Reverses words/letters	□Yes	□No When_____
Excessive eye rubbing?	□Yes	□No When_____	Moves lips while reading quietly	□Yes	□No When_____
Get lost in book?	□Yes	□No When_____	Moves head while reading	□Yes	□No When_____
Uses finger to follow words ?	□Yes	□No When_____	Tilts head while reading	□Yes	□No When_____

Does your child have speech or language deficit? □Yes □ No If yes, has any attempt been made to correct it? □ Yes □ No
By whom?_____ Was therapy successful? □ Yes □ No _____

School (please fill out if child is currently in school)

Age at time of entrance?_____Kindergarten_____First grade_____
Does child like school?_____Was a grade repeated?_____Which One?_____
Is school work? □ average □ better than average □ below average
Have there been any school difficulties? _____
What subjects are considered easiest?_____ most difficult?_____
Does test taking appear to cause anxiety? □Yes □No _____
Has your child ever been held back? □Yes □No If yes, what grade? _____
How did your child react to being held back? _____
Does the school consider your child to have a learning problem? □Yes □No _____
_____
Does the school consider your child to have a discipline problem? □Yes □No_____
_____
Does your child like to read? □Yes □No