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_____

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?_____
Any oxygen given Y____N____ If yes, amount of time on oxygen _____,
and reason _____
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? _____
_____.

Was there ever any reason for concern over your child's general growth and
development? Y____N____ If yes, please explain _____
_____.

PLEASE TURN OVER TO COMPLETE

Please check the following observations and/or complaints as they relate to your child.

_____Eyes turn in or out at any time, or eyes that do not appear straight
_____Eyelids droop
_____Turns the head to use one eye only
_____Covers or closes one eye
_____Blinks excessively
_____Places an object close to eyes to look at it
_____Stares at bright objects
_____Thrusts head forward or backward while looking at distance/near objects
_____Reddened eyes or eyelids
_____Frequent styes
_____Eyes in constant motion
_____Has watery eyes
_____Tilts head to one side
_____Has tendency to rub eyes
_____Abnormally bothered by bright lights
_____Squints while looking at objects
_____Avoids looking at/playing with close objects
_____Lacks interest in looking at objects
_____Stumbles over objects
_____Complains of headaches

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