Please take a few minutes to fill out this form. The information will make for better use of our appointment time. Also it will tell us what examination routines will best apply to your child's problem. This information is confidential and will not be released without your consent.

Child's full name _____
Nickname _____ Sex F M Age _____ Date of Birth ___/____/_____
Name of School _____ Grade _____ Teacher _____
1st Parent's Name _____Occupation _____
Address _____ City_____ State_____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
2nd Parent's Name _____Occupation _____
Address _____ City_____ State_____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____

Present situation:
1. In what way does your child seem to have visual difficulty?

2. How does your child complain about his/her vision?

Does child report or have you or anyone else ever noted	Yes	No	If yes, when?
1. Headaches			
2. Blurred Vision			
3. Double Vision			
4. Eyes 'hurt' or 'tired'			
5. Holding reading close			
6. Closing one eye			
7. Covering one eye			
8. Eyes frequently bloodshot			
9. Frequent styes			
10. Excessive eye rubbing			
11. Excessive blinking			
12. Getting lost in a book (not aware of surroundings)			
13. Tilting head when reading			
14. Inability to see distant objects			
15. Bumping into objects			
16. Poor general coordination			
17. Large pupils in normal light			
18. Bothered by light			
Other:			

School:

1. Age at time of entrance to: Kindergarten? _____ First Grade? _____
2. Does child like school? _____ Does child like teacher? _____
3. Has a grade been repeated? _____
4. Have there been any school difficulties? _____
5. Is school work: Average _____ Above average _____ Below average _____
6. Are there any subjects which seem particularly easy for the child? _____
7. Are there any subjects which seem particularly hard for the child? _____

Developmental History:

1. Was pregnancy full term? _____Was birth normal? _____
2. Complications before, during, or immediately follow delivery: _____
3. Did your child crawl? _____ All fours? _____ Age? _____
4. At what age did child walk? _____
5. First words? _____ Age? _____
6. Was child active? _____
7. When fatigued does child? Sag _____ Become irritable _____ Become excited _____
8. When under tension, is there any pattern of behavior, such as thumb sucking, nail biting, etc.?

_____

9. List major illnesses Age Severity_____

_____ Mild Moderate Severe

_____ Mild Moderate Severe

_____ Mild Moderate Severe

Visual History:

1. How long has difficulty been noticed? _____
2. Previous visual examinations? Age Doctor's Name Results_____

_____

_____

3. Family members who have had visual attention Age Visual Situation

_____

_____

Give a brief description of child's personality:

As you complete this history you will recognize the thoroughness with which your child's problem will be considered. The office examination will be a sufficient length to permit a very complete optometric investigation of the problem. Some parents have told us that being in the exam room during the evaluation was very helpful. If possible both parents may want to be present so that they will understand the child's needs and the doctor's observations and suggestions.

Thank you, Dr. Rebecca E Hutchins, O.D.