Children's Health History

Please indicate any symptoms or concerns about your child that the doctor should be informed:

_____

Name: _____ **Date:** _____

Visual History

1. Does your child have an eye turn? Yes / No
2. Does your child consistently rub his/her eyes? Yes / No
3. Does your child experience red or watery eyes? Yes / No
4. Does your child suffer from frequent headaches? Yes / No
5. Does your child wear glasses or contact lenses ? Yes / No

Questions about School Work

1. Does your child lose his/her place when reading? Yes / No
2. Does your child use a bookmark or finger to keep his/her place while reading? Yes / No
3. Does your child hold the reading material close to his/her face? Yes / No
4. Does your child experience eyestrain or headaches while doing work? Yes / No
5. Does your child experience difficulty with comprehension of written material? Yes / No
6. Does your child read comfortably in the car? Yes / No
7. Does your child reverse letters or words? Yes / No

Health History

Has your child has previous eye surgery? Yes / No

Has your child suffered eye injury? Yes / No

Has your child done vision therapy? Yes / No

Was your pregnancy normal with this child? If no please explain: Yes / No

When was your child's last medical exam?

_____

When was your child's last complete eye exam?

_____