Vision Enhancement Center of Optometry 951-686-3937 (eyes)

Today's Date: ___/___/_____

Child's Name ______________________________ Birth date: ___/____/____ Gender: M or F
Pediatrician ____________________ Date of last Physical Exam: ____________ Last Eye exam_________

Parent's Information

Father's Name______________________________ Cell/Home #____________________
Home Address____
Employer__________________________________ Work #______________________

Mother's Name______________________________ Cell/Home #____________________
Home Address____
Employer__________________________________ Work #______________________

What is the main reason for your child's visit today?______________________________
____
____

____

MEDICAL HISTORY _____ Child does NOT have any known medical disorders

Allergic Disorders: Child or Family (e.g. food, medication) ______________________
Cardiovascular: Child or Family (e.g. hypertension) ______________________
Constitutional: Child or Family (e.g. fatigue, irregular sleep) ______________________
Endocrine: Child or Family (e.g. diabetes, high cholesterol) ______________________
Gastrointestinal: Child or Family (e.g. acid reflux, ulcer) ______________________
Genitourinary: Child or Family (e.g. bladder infection, kidney stone) ______________________
Ears/Nose/Throat: Child or Family (e.g. sinus) ______________________
Hematologic: Child or Family (e.g. leukemia, anemia) ______________________
Immunologic: Child or Family (e.g. HIV, Lyme disease) ______________________
Integumentary: Child or Family (e.g. acne, psoriasis) ______________________
Musculoskeletal: Child or Family (e.g. Down's Syndrome, arthritis) ______________________
Neurological: Child or Family (e.g. epilepsy, Parkinson's Disease) ______________________
Psychiatric: Child or Family (e.g. ADD/ADHD, autism) ______________________
Respiratory: Child or Family (e.g. asthma) ______________________
Eyes: Child or Family (e.g. glaucoma, macular degeneration)______________________

List any allergies: ____None; If "yes": ______________________________________
MEDICATIONS &/or Vitamins (Please include over-the-counter)

____

List major illnesses & surgeries____

Your Child's Vision

Does your child currently wear glasses (Yes or No) or contact lenses (Yes or No)

Visual symptoms: Please indicate with a check mark (✓) the frequency your child experiences with the following

	Never	Seldom	Occasionally	Frequently	Always
Blurred Vision at near	____	____	____	____	____
Double Vision	____	____	____	____	____
Headaches associated with near work	____	____	____	____	____
Reading comprehension declines over time	____	____	____	____	____
Words run together when reading	____	____	____	____	____
Falling asleep when reading	____	____	____	____	____
Holding reading material too close	____	____	____	____	____
Skipping or repeating lines when reading	____	____	____	____	____
Dizziness or nausea asscociated with near work	____	____	____	____	____
Head tilt or closing one eye when reading	____	____	____	____	____
Difficulty copying from the chalkboard	____	____	____	____	____
Avoidance of reading and near work	____	____	____	____	____
Omitting small words when reading	____	____	____	____	____
Writing uphill or downhill	____	____	____	____	____
Misaligning digits in columns of numbers	____	____	____	____	____
Burning, stinging, watery eyes	____	____	____	____	____
Inconsistent/poor sports performance	____	____	____	____	____
Vision worse at the end of the day	____	____	____	____	____
Short attention span	____	____	____	____	____
Difficulty completing work in reasonable time	____	____	____	____	____
Saying "I can't" before trying	____	____	____	____	____
Avoiding sports and games	____	____	____	____	____
Difficulty with tools, scissors, calculator, keys	____	____	____	____	____
Inability to estimate distance accurately	____	____	____	____	____
Tendency to knock things over on desk or table	____	____	____	____	____
Difficulty with time management	____	____	____	____	____
Difficulty with money concepts, making change	____	____	____	____	____
Misplaces or loses papers, objects, belongings	____	____	____	____	____
Car sickness/ motion sickness	____	____	____	____	____
Forgetful, poor memory	____	____	____	____	____

DEVELOPMENTAL HISTORY

Any complications during pregnancy or birth? Y or N: If yes, please explain:______________________________

____

Was your child born premature? Y or N: If yes, # of weeks:_________ Birth Weight: _________Height: _______
Did your child crawl? Y or N: If yes, at what age:___________ At what age did your child walk? ___________
First words at what age? _________ Is speech clear now? Y or N Any hearing problem? Y or N

EDUCATIONAL HISTORY

Current Grade: ________School: ____ Teacher: _______________
Does your child like school? Y or N; If No, please explain: ____
Does your child like to read? Y or N; If Yes, what topic (s)? __________________________Reading level: ______
School work is: above average: _____ average: ____ below average: ____
Has your child ever repeated a grade? ____ No; If yes, which one(s)? ______________________________________
Does your child receive any special services from the school? Y or N
(e.g. speech and language, occupational therapy, large print, more time)
If yes, indicate type and how often: ___________ ____

COMPUTER / VIDEO GAME /TABLET USE

Does your child use a computer? _________ Hrs/Day
Hand-held video game? __________________ Hrs/Day
Tablet use? ______________________________ Hrs/Day

Does your child experience symptoms when using devices: (check (✓) all that apply)

___Tired eyes ____Dry eyes ____Headaches ____Blurred vision ____Double vision ____Red eyes

Other: ____

SPORTS AND LEISURE

What sports / recreational activities does your child participate in? _______________________________________

____

Does your child use any eyewear for sports? Y or N
If "Yes":____ Contact Lens ____ Glasses/Sport goggles____Other:____

Thank you for completing this questionnaire and for choosing our office. The information supplied will allow for more efficient time during the examination and will permit us to make a complete optometric evaluation of your child's visual system related to his/her specific needs.