# PERSONAL INFORMATION *CHILD*

*Child's Name*______________________________

*Name of Person Completing Form*______________________________

*Your Relationship to Child*______________________________

*Has your child ever had any of the following?*

| | | |
|---|---|---|
| Eye Surgery | ○ Yes | ○ No |
| Eye Injury | ○ Yes | ○ No |
| Eye Infection | ○ Yes | ○ No |
| Vision Therapy | ○ Yes | ○ No |
| Eye Patching | ○ Yes | ○ No |

*Does your child have any of the following?*

| | | |
|---|---|---|
| An eye that turns inward | ○ Yes | ○ No |
| An eye that turns outward | ○ Yes | ○ No |
| An eye that turns up or down | ○ Yes | ○ No |
| Red eyes | ○ Yes | ○ No |
| Watery eyes | ○ Yes | ○ No |
| Headaches | ○ Yes | ○ No |
| Frequent episodes of squinting | ○ Yes | ○ No |
| Frequent episodes of eye rubbing | ○ Yes | ○ No |
| A tendency to turn or tilt head | ○ Yes | ○ No |

*Was the pregnancy full term for this child?* ○ Yes ○ No

*Please check any of the following that occurred during the pregnancy of this child:*
○ Mother Injury ○ Drug/Alcohol Use ○ Gestational Diabetes ○ Toxemia

*What was the type of delivery?* ○ Natural ○ Caesarian ○ Forceps or Instruments ○ Anesthesia

*Were there any problems during delivery?* ○ Yes ○ No *If yes, explain?*____________________

______________________________

*Was oxygen provided to this child?* ○ Yes ○ No *If yes, for how long?*____________________

*Is your child developmentally on track?* ○ Yes ○ No

## SCHOOL AGE CHILDREN:

*Child's Grade Level*____________________

*Does your child perform on grade level in:*

| | | |
|---|---|---|
| Reading | ○ Yes | ○ No |
| Math | ○ Yes | ○ No |
| Spelling | ○ Yes | ○ No |

*Does your child:*

| | | |
|---|---|---|
| Close or cover one eye while reading | ○ Yes | ○ No |
| Frown, scowl while reading/writing | ○ Yes | ○ No |
| Easily lose his/her place while reading | ○ Yes | ○ No |
| Frequently re-read words | ○ Yes | ○ No |
| Omit words while reading | ○ Yes | ○ No |
| Make mistakes when copying from the board | ○ Yes | ○ No |
| Avoid close work like reading | ○ Yes | ○ No |

*Many vision and health problems run in families. Please indicate below if any of the child's immediate family has the following:*

| *Disease/Condition* | | | *Relationship to Child* |
|---|---|---|---|
| Strabismus (Eye Turns) | ○ Yes | ○ No | __________ |
| Amblyopia (Lazy Eye) | ○ Yes | ○ No | __________ |
| Childhood Glaucoma | ○ Yes | ○ No | __________ |
| Childhood Cataracts | ○ Yes | ○ No | __________ |

| *Disease/Condition* | | | *Relationship to Child* |
|---|---|---|---|
| High Nearsightedness | ○ Yes | ○ No | __________ |
| High Farsightedness | ○ Yes | ○ No | __________ |
| Learning Disability | ○ Yes | ○ No | __________ |

*Parent or Guardian Signature*______________________________ *Date:*__________