

Developmental History ~ Children's & Family Eyecare

Child's Name _____ Birthday ____/____/____ Age ____ Yr ____ Mo ____

Grade: ____ School's Name and Address: _____

Teacher's Name: _____

Mother's Name: _____ Occupation: _____ Phone: _____

Father's Name: _____ Occupation: _____ Phone: _____

Mailing Address: _____

Who referred you to this clinic? _____ Number of Children in Family _____

I. Please state the major reasons you would like your child examined: _____

II. Vision	Yes	No	Comments
Headaches			
Blurred Distance Vision			
Blurred Reading Vision			
Holds Books Closer than Normal			
Eyes Hurt			
Eyes Tire			
Eye Turn (crossed or wall-eyed)			
Blinks Excessively			
Covers One Eye While Doing Homework			

III. School	Yes	No	Comments
Is your child having problems in school?			
Does your child like the teacher?			
Is school satisfied with child's performance?			
Are you satisfied with child's performance?			
Do grades really show his/her ability?			
Is there trouble completing written assignments?			
Does your child lose his/her place while reading?			
Does your child misread words that are known?			

IV. Behaviors: Please rate your child: (Place a number in the blank space to the left of the item)

1- Always 2- Frequently 3- Occasionally 4- Rarely 5- Never 6- Unknown

___ Hyperactive	___ Poor Ability to Organize Work	___ Confusion Following Verbal Instructions
___ Easily Distracted	___ Indistinct Speech	___ Variable School Performance, hour to hour
___ Short Attention Span	___ Awkward or Clumsy	___ Reverses letters, words, or number's in reading
___ Easily Frustrated	___ Poor Peer Group Relationships	___ Reverses letters, words, or number's in writing
___ Impulsive	___ Behavioral Problems	___ Shows Confusion about Right and Left
___ Easily Fatigued	___ Emotional Problems	___ Shows confusion about directional orientation

V. Physical Development: At what age in years and months did your child:

Speak words clearly _____ start to crawl _____ walk unaided _____

Which phrase describes the child's physical maturity (please circle number)?

- 1- Physically Immature for age 2- Average physical maturity for age 3- Advanced physical maturity

VI. School Progress: Rate your child's progress in the following subjects: (1= below grade, 2= grade level, 3= above grade)

_____ -Reading _____ -Spelling _____ -Writing _____ -Arithmetic _____ -Art _____ -PE _____ -Other? _____

What specific type(s) of work is your child having difficulty with? _____

Have other family members had difficulties learning any of the above subjects? No _____ Yes _____

If yes, state relationship to child and subjects: _____

Does your child have memory difficulties? No _____ Yes _____ If so, what type of information? _____

VII. General History: Is there a history of pregnancy or birth complications? No _____ Yes _____

If yes, please explain: _____

Has there been any severe childhood illness, high fever, injury or physical impairment? No _____ Yes _____

If yes, please explain: _____

Has your child received a hearing test? No _____ Yes _____ Date _____

Has a hearing or speech deficiency been diagnosed? No _____ Yes _____

If yes, please explain: _____

Has your child had any ear infections in the past (Y/N)? _____ If yes, how many? _____ both ears (Y/N)? _____ tubes (Y/N)? _____

Has your child received a complete eye examination? No _____ Yes _____ Date _____ Drops used (Y/N)? _____

Has a visual problem been diagnosed? _____

Does your child have any allergies? No _____ Yes _____, if yes, to what? _____

Is your child currently taking any medications or pills? No _____ Yes _____

If yes, please list the medications, their purpose, and duration: _____

Has your child previously taken medication for hyperactivity? No _____ Yes _____

VIII. Therapy: Has there been any previous therapy for learning difficulties or visual or speech problems? No _____ Yes _____

If yes, please state the type of therapy, duration, and results: _____

Signature: _____ Date: _____

Relationship to child: _____ Comments: _____