Southeastern Indiana Vision Development Center

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211 East Main Street
Greensburg, IN 47240

Child's full name_____DOB_____ Age Now_____
Complete Address_____
_____
Father/Guardian's name_____ Home phone_____
Cell phone_____
Occupation_____ Business phone_____
Mother/Guardian's name_____ Home/cell phone _____
Cell phone _____
Occupation_____ Business phone_____
Siblings (age and sex)_____
Name of School_____ Current Grade_____
Address_____ Teacher's Name _____
Referred by_____
Reason for referral_____
What do you expect to find out from the exam _____
Pediatrician's name/address _____
_____
Last medical exam _____ Medical problems?_____
Present medications_____ Allergies? _____
Family history of eye or health problems?: _____
_____

PRESENT SITUATION: In what ways does your child seem to have difficulty? How does your child complain about his or her vision?

_____
_____

Has anyone noticed an eye turn in or wander out? □ Yes □ No Which eye?_____When? _____

Does your child ever report any of the following, and if yes, when?

Headaches	☐Yes ☐No	When _____	Eyes hurt or tired	☐Yes ☐No	When _____
Blurred Vision Far	☐Yes ☐No	When _____	Double Vision	☐Yes ☐No	When _____
Blurred at Near	☐Yes ☐No	When _____	Light sensitivity	☐Yes ☐No	When _____

Have you ever noticed the following? If yes, when?

Holding reading close	☐Yes ☐No	When_____	Distorted posture when reading?	☐Yes ☐No	When_____
Holding reading further away	☐Yes ☐No	When_____	Inability to see distance objects?	☐Yes ☐No	When_____
Closing one eye?	☐Yes ☐No	When_____	Bumping into objects?	☐Yes ☐No	When_____
Covering one eye?	☐Yes ☐No	When_____	Poor general coordination?	☐Yes ☐No	When_____
Eyes frequently reddened?	☐Yes ☐No	When_____	Skips words or rereads	☐Yes ☐No	When_____
Frequent styes?	☐Yes ☐No	When_____	Reverses words/letters	☐Yes ☐No	When_____
Excessive eye rubbing?	☐Yes ☐No	When_____	Moves lips while reading quietly	☐Yes ☐No	When_____
Get lost in book?	☐Yes ☐No	When_____	Moves head while reading	☐Yes ☐No	When_____
Uses finger to follow words ?	☐Yes ☐No	When_____	Tilts head while reading	☐Yes ☐No	When_____

Does your child have speech or language deficit? ☐ Yes ☐ No If yes, has any attempt been made to correct it? ☐ Yes ☐ No
By whom?_____ Was therapy successful? ☐ Yes ☐ No _____

PLEASE TURN OVER TO COMPLETE

Developmental History

Is the child adopted? ____ If yes, does the child know? _____ Age when adopted _____
Full term pregnancy?_____Normal birth?_____
Any complications before, during, or following delivery?_____
Was the child exposed in utero to: ☐ drugs ☐ alcohol ☐ nicotine ☐ tobacco
Did your child crawl? ☐Yes ☐ No Age_____ Age at which child walked?_____
Age of speech: First words?_____Sentences?_____
When fatigued, child will: Sag_____Becomes irritable_____excited_____
Under tension, is there any pattern of behavior, thumb-sucking, etc? _____
_____

School

Age at time of entrance?_____Kindergarten_____First grade_____
Does child like school?_____Favorite part of school?_____Least favorite?_____
Is school work? ☐ average ☐ better than average ☐ below average
Have there been any school difficulties? _____
What subjects are considered easiest?_____ most difficult?_____
Does test taking appear to cause anxiety? ☐Yes ☐No _____
Has your child ever been retained? ☐Yes ☐ No If yes, what grade? _____
How did your child react to retention? _____
Does the school consider your child to have a learning problem? ☐Yes ☐ No _____
_____
_____
Does the school consider your child to have a discipline problem? ☐Yes ☐No_____
_____
Does your child like to read? ☐ Yes ☐ No

Visual History

How long has difficulty been noticed?_____
Previous visual examinations:
Reason for examination Doctor's Name Date Result
_____
_____
_____

Members of family who have had visual attention issues and why:
Name Age Visual Situation
_____
_____
_____
_____

Give a brief description of your child as a person:
_____
_____
_____
_____

As you complete this history questionnaire you will recognize the thoroughness with which your problem will be considered. The office examination will take up enough time to permit a very complete optometric investigation of the problem. Your child's future deserves the fullest consideration that you as parents and we here in the office can provide. In order for us to keep costs down, payment is expected in full at the time of service. We do not accept assignment from insurance companies. All payments are between the patient and our office.

I authorize the release of medical and/or other information pertinent to my child's care to the Southeastern Indiana Vision Development Center to help facilitate proper care.

Parent/Guardian Signature:_____Date:_____