EYECARE ROCKWALL

Developmental Eye Examination

General Information

Patient: _____ Date: _____ DOB: _____

Were you referred to our office? ☐ No ☐ Yes, by whom? _____ Phone: _____

Child's handedness: ☐ Right ☐ Left

Developmental and Health History

PREGNANCY

Length of Pregnancy: ____weeks List any pregnancy complications:_____

DELIVERY

Birth Weight _____lbs _____oz Parents ages at time of birth: Mother _____ Father _____

Any delivery complications? ☐ No ☐ Yes, _____

Was oxygen used? ☐ Yes ☐ No APGAR score (if known): _____

DEVELOPMENTAL

Did your child creep (stomach on floor)? ☐ No ☐ Yes, age: _____

Did your child crawl? ☐ No ☐ Yes, age: _____

At what age did your child walk? _____ Was your child active? ☐ Yes ☐ No

When were your child's first words? _____ Does child speak clearly now? ☐ Yes ☐ No

MEDICAL

Has your child ever had a high temperature/fever? ☐ No ☐ Yes, how high? _____

Please list any childhood illnesses your child has had:

Illness: _____ Age: _____ ☐ Mild ☐ Moderate ☐ Severe

Illness: _____ Age: _____ ☐ Mild ☐ Moderate ☐ Severe

Is your child generally healthy: ☐ Yes ☐ No

Any chronic problems like ear infections, asthma, hay fever, allergies? ☐ No ☐ Yes: _____

List any accidents, eye, or head injuries, and age they occurred: _____

Please list any other conditions we should know about: _____

NUTRITIONAL INFORMATION

Current Diet: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Does your child: Like Sweets? ☐ Yes ☐ No Crave Sweets? ☐ Yes ☐ No

Is your child active? ☐ No ☐ Yes, ___Moderately ___Extremely

Are there periods of: Very high energy? ☐ Yes ☐ No Very low energy? ☐ Yes ☐ No

Visual History

Has your child ever been prescribed glasses? ☐ No ☐ Yes, for ☐ distance only ☐ reading only ☐ full-time wear

Does your child wear their glasses as prescribed? ☐ Yes ☐ No

Do any biological family members have: Lazy Eye (Amblyopia) ☐ Yes ☐ No

Eye Turn (Strabismus) ☐ Yes ☐ No

Eye Tumor ☐ Yes ☐ No

Is there any evidence from school and/or psychological testing that indicate some visual malfunction may be present? ☐ No ☐ Yes, please explain: _____

Schooling

Name of school: _____

Current Grade: _____ Teacher: _____ Does your child like school? ☐ Yes ☐ No

Age at time of entrance to: Kindergarten _____ First Grade _____

Any grades repeated in school? ☐ No ☐ Yes, which grade? _____

Has your child changed schools often? ☐ No ☐ Yes, when? _____

Has your child been placed on an Individualized Education Program? ☐ No ☐ Yes

Does your child seem to be under tension or extreme pressure when doing school work? ☐ Yes ☐ No

Has your child had any special tutoring or received special services from a:

☐ Tutor: Name _____ When _____ Results _____

☐ OT: Name _____ When _____ Results _____

☐ PT: Name _____ When _____ Results _____

☐ Speech Path: Name _____ When _____ Results _____

Which school subjects are easy for your child? _____

Which school subjects are difficult for your child? _____

Does your child like to read? ☐ Yes ☐ No Voluntary reader? ☐ Yes ☐ No

What does your child like to read? _____

Specifically describe any school difficulties: _____

What is your child's attitude towards reading/school/teachers/peers? ☐ Positive ☐ Negative ☐ Neutral

School work is: ☐ Above average ☐ Average ☐ Below average

Do you feel like your child is achieving up to their full potential? ☐ Yes ☐ No

Does the teacher feel like your child is achieving up to their full potential? ☐ Yes ☐ No

General Behavior

Are there behavior problems at school? ☐ Yes ☐ No Are there behavior problems at home? ☐ Yes ☐ No

What causes these problems? _____

Does your child say and/or do things impulsively? ☐ Yes ☐ No

Is your child in constant motion? ☐ Yes ☐ No Can your child sit still for long periods? ☐ Yes ☐ No

Family and Home

Has your child ever been through a difficult family situation (divorce, parental loss, separation, severe parental illness? ☐ Yes ☐ No What age was your child? _____ Has your child since adjusted? ☐ Yes ☐ No

How does your child get along with:

Parents? _____

Sibilings? _____

Classmates in school? _____

Playmates at home? _____

Did father or anyone in father's family have a learning disability? ☐ No ☐ Yes, who? _____

Did mother or anyone in mother's family have a learning disability? ☐ No ☐ Yes, who?_____

Do any siblings have a learning disability? ☐ No ☐ Yes, who?_____

Please give a brief description of your child as a person:

_____

_____

_____

_____

RELEASE OF INFORMATION AND INSURANCE

I agree to permit information from, or copies of, my child's examination records to be forwarded to other health care providers or insurance carriers upon written request or upon the recommendation of the doctors at Eyecare Rockwall when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims.

_____ _____

Signature Date