EYECARE ROCKWALL

Pediatrics Eye Examination History

Patient: _____ Date: _____ DOB: _____

Eye History

Have you ever noticed any of the following happening with your child's eyes? (please check all that apply)

Eye turn: ☐ In ☐ Out ☐ Eyes watering ☐ Eyes red ☐ Swelling around eyes ☐ White appearance in pupil

Explain any eye-related concerns: _____

_____

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? _____

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

MEDICAL

Child's doctor: _____ Last exam date: _____ Immunizations up to date? ☐ Yes ☐ No

Any developmental delays? _____

Check all of the following that your baby can do at this time: ☐ Roll over ☐ Sit ☐ Crawl ☐ Stand ☐ Walk

Approximate age your child began: Rolling over: _____ Sitting: _____

Crawling: _____ Standing: _____ Walking: _____

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

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

Please list any other conditions we should know about: _____

Family History

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

Eye Turn (Strabismus) ☐ Yes ☐ No

Eye Tumor ☐ Yes ☐ No

Schooling

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

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

Check all that apply: ☐ Avoids reading/homework/near activities ☐ Complains of headaches ☐ Squints

☐ Complains of difficulty seeing things far away ☐ Struggles in school ☐ Struggles in sports

Patient Name: _____ Date: _____

Person Completing Checklist: _____

Check the column which best represents the occurrence of each symptom:

	Never	Seldom	Occasionally	Frequently	Always
Headaches with near work					
Double vision					
Words run together while reading					
Burning, itching, watery eyes					
Skips/repeats lines while reading					
Head tilt or closes one eye when reading					
Difficulty copying from chalkboard					
Avoids near work/reading					
Omits small words when reading					
Writes up or downhill					
Misaligns digits/columns of numbers					
Reading comprehension down					
Holds reading material too close					
Trouble keeping attention on reading					
Difficulty completing assignments on time					
Always says “I can't” before trying					
Clumsy, knocks things over					
Doesn't use his/her time well					
Loses belongings/things					
Forgetful/poor memory					