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Please bring this form to your child's appointment. This assists us in determining the visual performance tests needed. If your child has an Individual Education Plan (IEP), or other testing which we should be aware of, please provide a copy.

School Age Child History (4-21 years)

Date _____ Completed By _____
How did you learn about A B See? _____

General Information

Child's name

(LAST) (FIRST) (M)
Birth Date _____ Age _____ Grade ____ Gender F M
Home Address _____
City _____ State _____ Zip _____
Name of Health Care Plan _____
Policy Holder _____
Policy number _____ Group# _____
Medical Billing Address _____

Pediatrician _____
Pediatrician's phone number _____

Parent / Guardian Information

Parent 1 /Guardian Name

(LAST) (FIRST) (M)
Home Address _____
City _____ State _____ Zip _____
Home phone () _____
Cell phone () _____
E-mail _____
Parent occupation _____
Employer _____
Work phone () _____
May we contact you at your business? Yes No

Parent 2 /Guardian Name

(LAST) (FIRST) (M)
Home Address _____
City _____ State _____ Zip _____
Home phone () _____
Cell phone () _____
E-mail _____
Parent occupation _____
Employer _____
Work phone () _____
May we contact you at your business? Yes No

Responsible party _____
Phone () _____

Medical History

Most recent medical examination:

Date: _____

Doctor's name: _____

Results: _____

Current Medications:

Taken For:

| | |
|--|--|
| | |
| | |
| | |
| | |
| | |
| | |

Is your child generally healthy? _____

Are there any chronic problems like asthma, hay fever or allergies? _____

If so, please list: _____

Has a neurological evaluation been performed? _____

By whom? _____

Results: _____

Has a psychological evaluation been performed? _____

By whom? _____

Results: _____

Has your child been diagnosed as having:

- Learning Disabilities Developmental delays
- ADD or ADHD Cerebral Palsy
- Seizure Disorders Autism
- Other problems _____

List illnesses, bad falls, head injuries, high fever, surgeries etc. _____

Complications and ages: _____

Medical History continued

Please check any of the following which your child has or has had in the past:

Allergies/ Immunology

- _____ Drug Allergies
_____ Environmental Allergy
_____ Rheumatoid Arthritis
_____ Lupus
_____ Other

List all allergies:

Psychiatric

- _____ Depression
_____ Panic Disorder
_____ Schizophrenia
_____ Memory Loss
_____ Other

Explain:

Integumentary

- _____ Eczema
_____ Rosaces
_____ Psoriasis
_____ Ring Worm
_____ Other

Explain:

Musculoskeletal

- _____ Fibromyalgia
_____ Muscular Dystrophy
_____ Osteoarthritis
_____ Cold Extremities
_____ Other

Explain:

Constitutional

- _____ General Good Health
_____ Recent Weight Change
_____ Fever
_____ Fatigue
_____ Developmental Disability
_____ Other

Explain:

Eye/Ear/Nose

- _____ Tubes in Ears
_____ Earaches or Drainage
_____ Chronic Sinus Problems
_____ Glaucoma
_____ Cataracts
_____ Eye Turn
_____ Hearing Loss Injury
_____ Other

Explain:

Hematological/ Lymphatic

- _____ Anemia
_____ Bleeder
_____ Slow to heal after cut
_____ Leukemia
_____ Large volume blood loss
_____ Enlarged glands
_____ Blood transfusions
_____ Other

Explain:

Endocrine

- _____ Non insulin dep. Diabetic
_____ Insulin dep. Diabetic
_____ Thyroid dysfunction
_____ Hormonal dysfunction
_____ Other

Explain:

Respiratory

- _____ Allergies
_____ Cigarette Smoker
_____ Asthma
_____ Bronchitis
_____ Other

Explain:

Neurological

- _____ Paralysis
_____ Numbness or Tingling
_____ Headaches
_____ Light Headed or Dizzy
_____ Convulsions/ Seizures
_____ Tremors
_____ Head Injuries
_____ Other

Explain:

Gastrointestinal

- _____ Loss of appetite
_____ Bowel movement changes
_____ Abdominal pain
_____ Crohn's
_____ Colitis
_____ Ulcers
_____ Other

Explain:

Cardiovascular

- _____ Heart Disease
_____ Hypertension
_____ Stroke
_____ Vascular Disease
_____ Other

Explain:

Does your child currently receive:

Occupational therapy services? _____

By Whom? _____

Results: _____

Physical therapy services? _____

By whom? _____

Results: _____

Speech therapy services? _____

By whom? _____

Results: _____

Nutritional Information

Current Diet: Excellent Good Fair Poor

Does your child crave sweets? _____

Is your child: Moderately active Extremely active

Are there periods of high energy? _____

Low energy? _____

Developmental History

Full term pregnancy? _____ Normal birth? _____

Birth weight? _____

Any complications before, during, after or immediately following delivery? _____

Did your child crawl (stomach on floor)? _____

Age: _____

Did your child creep (stomach off floor)? _____

Age: _____

Did your child move on all fours? _____

Age: _____

If not describe: _____

At what age did your child walk? _____

Was child active? _____

Speech: First words at age: _____

Was early speech clear to others? _____

Is it clear now? _____

Any history of crossing eyes? Yes No

What age first noticed? _____

Any family history of crossing eyes? Yes No

Who? _____

How would you describe your child's gross motor skills? (i.e. running, jumping, hopping) _____

fine motor skills? (i.e. tying shoes, cutting) _____

Visual History

Previous eye examination:

Date: _____

Doctor's name: _____

Location: _____

Reason for examination: _____

Were glasses prescribed? Yes No

How are they worn? _____

Are contact lenses worn? Yes No

How are they worn? _____

When was the visual difficulty first noted? _____

Did the problem occur suddenly or related to illness, accident, or trauma? Explain: _____

Have there been any treatments to remedy the problem, such as:

Vision therapy _____

Patching _____

Eye surgery _____

Other _____

Have you seen improvements with therapy? _____

Present Visual Situation

Is there any evidence from any other professional that some visual malfunction may be present? _____

If so, what? _____

Does your child report any of the following:

Headaches: Yes No

When? _____

Blurred vision: Yes No

When? _____

Double Vision: Yes No

When? _____

Eyes "hurt or tired": Yes No

When? _____

List any other complaints that your child makes concerning his/her vision: _____

Have you ever noticed the following:

Eyes frequently reddened: Yes No

If so, when? _____

Frequent eye rubbing: Yes No

If so, when? _____

Frequent blinking: Yes No

If so, when? _____

Closing or covering one eye: Yes No

If so, when? _____

Yes No Head close to paper when reading or writing

Yes No Tilting head when reading

Yes No Tilting head when writing

Yes No Confuses letters or words

Yes No Reverses letters or words

Yes No Skips, re-reads or omits words

Yes No Vocalizes when reading silently

Yes No Reads Slowly

Yes No Uses finger as a marker

Yes No Poor reading comprehension

Yes No Writes or prints poorly

Yes No Tires easily

Yes No Avoids near tasks

Yes No Short attention span

Yes No Poor motor coordination

Yes No Difficulty catching/ hitting a ball

Screen Time

Cell Phone _____ hours per day

Chromebook/ipad/laptop _____ hours per day

Gaming Handheld _____ hours per day

Gaming on Large Screen _____ hours per day

Television viewing: How much? _____

How often? _____ Viewing distance? _____

Members of the family who have had visual problems and why:

| Name | Age | Visual Situation |
|------|-----|------------------|
|------|-----|------------------|

School 1st - 12th Grade

Name of Current School: _____

School Address: _____

City _____ State _____ Zip _____

School Phone: (_____) _____

Teacher's Name: _____

Grade: _____

Has a grade been repeated? Yes No

Which one? _____

Has he/she changed schools often? Yes No

When? _____

Age at entrance to kindergarten: _____

Age at entrance to first grade: _____

Does child like school? Yes No

Does child like teacher? Yes No

School work/grades in the following classes are at which level? (please check)

| | Above Average | Average | Below Average |
|----------|------------------|---------|------------------|
| Reading | _____ | _____ | _____ |
| Math | _____ | _____ | _____ |
| Spelling | _____ | _____ | _____ |
| Writing | _____ | _____ | _____ |
| Gym | _____ | _____ | _____ |

Do you feel he/she is working up to potential? _____

Does teacher feel he/she is working up to potential? _____

What school subjects come easy for child? _____

Does child like to read? _____

Does child like to read voluntarily? Yes No

Yes No

Has he/she had any special tutoring and/or remedial assistance? Yes No

When? _____

From whom? _____

Where? _____

How long? _____

Results: _____

Does he/she seem to be under tension or extreme pressure when doing school work? _____

How well developed is his/her spoken vocabulary? _____

What is the child's attitude toward reading, school, his/her teacher, other youngsters? _____

Specifically describe any school difficulties: _____

College/Technical College

Major _____

Specifically describe any school difficulties: _____

General Behavior

Are there any behavior problems? _____

School: _____ Home: _____

What causes these problems? _____

Child's reaction to fatigue: _____

Sad: _____ Irritable: _____ Other: _____

Child's reaction to tension: Nail biting: _____

Thumb sucking: _____ Other: _____

Have you ever noticed the following:

- Yes No Says and/or does things impulsively?
- Yes No Is in constant motion?
- Yes No Can't sit still for long periods?
- Yes No Can't watch TV over 15 minutes?
- Yes No Speech difficult to understand?
- Yes No Stutters?
- Yes No Omits parts of word?
- Yes No Asks for frequent repetitions?
- Yes No Difficulty expressing thoughts?

Family and Home (optional)

The following information lets the doctor know who will be performing home therapy with your child. It also lets us know if you need duplicate materials to aid in effective home therapy

Please indicate which adults he/she lives with:

Mother _____ Father _____ Step Mother _____

Step Father _____ Foster Parents _____

Caregiver _____ Grandmother _____

Grandfather _____ Aunt _____ Uncle _____ Other _____

Siblings: Names _____ Ages _____

If applicable, please describe your child's custody agreement:

Family History (Learning Problems)

Did father or anyone in father's family have learning problems? Yes No

Who? _____

Did mother or anyone in mother's family have learning problems? Yes No

Who? _____

Do any, or did any of the other children in the family have learning problems? Yes No

Who? _____

To what extent? _____

Is there anything else you would like us to know about your child? _____

Patient's Name _____ Date _____

COVID-Quality of Life Questionnaire

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

Completed by: _____

| | Never | Seldom | Occasional | Frequently | Always |
|--|-------|--------|------------|------------|--------|
| Headaches with near work | | | | | |
| Words run together when reading | | | | | |
| Burning, itchy, watery eyes | | | | | |
| Skips/repeats lines when reading | | | | | |
| Head tilt/closes one eye when reading | | | | | |
| Difficulty copying from the chalkboard | | | | | |
| Avoids near work/reading | | | | | |
| Omits small words when reading | | | | | |
| Writes up/down hill | | | | | |
| Misaligns digits/columns of numbers | | | | | |
| Difficulty comprehending what is read | | | | | |
| Holds document/book too close | | | | | |
| Trouble keeping attention on reading | | | | | |
| Difficulty completing assignments | | | | | |
| Always says "I can't" before trying | | | | | |
| Clumsy, knocks things over | | | | | |
| Does not use his/her time well | | | | | |
| Loses belongings/things | | | | | |
| Forgetful/poor memory | | | | | |

Other comments: