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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 _____

Parent Information

Father's name

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

Mother's Name

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

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? Yes No

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? _____

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

Have you ever noticed the following: Yes No

Eyes frequently reddened: Yes No

If so, when? _____ Yes No

Frequent eye rubbing: Yes No

If so, when? _____ Yes No

Frequent blinking: Yes No

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

Television viewing: How much? _____

How often? _____ Viewing distance? _____

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

Name	Age	Visual Situation
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Other related information regarding vision: _____

School 1st - 12th Grade

Name of Current School: _____

School Address: _____

City _____ State _____ Zip _____

School Phone: () _____

Teacher's Name: _____

Grade: _____ Yes No

Has a grade been repeated? Yes No
Which one? _____

Has he/she changed schools often?
When? _____ Yes No
_____ Yes No

Age at entrance to kindergarten: _____

Age at entrance to first grade: _____

Does child like school?

Does child like teacher?

Currently what are average grades overall:

A B C D F

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?

_____ Yes No
_____ Yes No

What school subjects come easy for child?

_____ Yes No _____

Does child like to read?

Does child like to read voluntarily?

Has he/she had any special tutoring and/or remedial assistance?

When? _____

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: _____

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: