TO THE PARENTS OF

The following information will allow us to make more complete use of the time we will devote to your child.

CHILD'S FULL NAME_____ Present Age____ Birthdate_____

Name and address of School_____

Grade____ Teacher_____ School Nurse_____

A. PRESENT SITUATION:

1. Describe any indications of visual difficulty_____

2. Does your child report any of the following?

   a. Headaches: Yes____ No____ When?_____

   b. Blurred vision: Yes____ No____ When?_____

   c. Double vision: Yes____ No____ When?_____

   d. Eyes 'hurt' or 'tired': Yes____ No____ When?_____

3. List any complaints your child makes concerning his/her vision

B. HAVE YOU OR ANYONE ELSE EVER NOTED THE FOLLOWING:

	Yes	No	When?
1. Holding reading close?			
2. Head close to paper when writing or drawing?			
3. Closing one eye?			
4. Covering one eye?			
5. Eyes frequently reddened?			
6. Frequent styes?			
7. Excessive eye rubbing?			
8. Excessive blinking?			
9. Losing place when reading?			
10. Tilting head when reading?			
11. Poor posture when reading?			
12. Inability to see far objects?			
13. Bumping into objects?			
14. Poor general coordination?			
15. Large pupils in normal light?			
16. Bothered by light?			
17. Behaviour problems?			

C. SCHOOL:

1. Age at time of entrance to Kindergarten_____ First Grade_____
2. Does child like school? Yes_____ No_____ Teacher? Yes_____ No_____
3. Has grade been repeated? Yes_____ No_____ Which?_____

4. Describe any school difficulties_____

5. School work is: Above average_____Average_____Below average_____
6. School subjects easy for child:_____
7. School subjects difficult for child:_____
8. Does child like to read?_____Voluntarily?_____What?_____

D. DEVELOPMENTAL HISTORY:

1. Full term pregnancy?_____Normal birth?_____Any complications before, during or immediately following delivery?_____
2. Did your child crawl (stomach on floor)?_____Age_____Creep (stomach off floor)?_____Age_____ All fours?_____If not, describe_____
3. At what age did your child walk?_____
4. Was child active?_____
5. Speech: First words at age_____Was early speech clear to others?_____Is it clear now?_____
6. Child's reaction to fatigue: Sags_____Becomes irritable_____Becomes excited_____ Other_____
7. What is your child's reaction to tension? Thumb sucking_____Nail biting_____ Other_____
8. List illnesses:

Illness	Age	Mild	Severe	Complications

E. VISUAL HISTORY:

1. Previous examinations:

Reason for examination	Doctor's Name	Date	Results

2. Members of family who have had visual attention and why:

Name	Age	Visual Situation

F. GIVE A BRIEF DESCRIPTION OF THIS CHILD AS A PERSON:

The office examination will take sufficient time to permit a very complete optometric assessment of your child's vision. It is desirable to have both parents present during the examination. We have found it difficult for either the mother or father to carry home the full information about the child to the other parent. Your child's future deserves the fullest consideration that you as parents, and we here in the office, can provide.

Thank you,

Present Date:_____

_____O.D.
Optometrist