

Drs. Rick Thompson, Angela Peddle, & Virginia Donati Optometrists

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Child's Full Name: _____	Date of Birth (mm/dd/yy): _____
Home Address: _____ _____	Health ID#: _____
Phone Number: _____	Parent(s) Name: _____
How were you referred to us: _____	Email: _____

HEALTH HISTORY

Family Doctor: _____	Any Allergies: _____
Any Hospitalizations: _____	Medication: _____

Any history of:

- | Self | Family | Self | Family | Self | Family |
|--------------------------|--|--------------------------|---|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> | <input type="checkbox"/> HIV/Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> Stroke | <input type="checkbox"/> | <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> | <input type="checkbox"/> Neuromuscular |
| <input type="checkbox"/> | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> Colour Blindness | <input type="checkbox"/> | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> Arthritis | | |
| <input type="checkbox"/> | <input type="checkbox"/> Cataracts | <input type="checkbox"/> | <input type="checkbox"/> Tuberculosis | | |

VISUAL HISTORY

Is this your child's first visual examination? Yes No

If not, when was their last examination? _____

Any learning-related diagnoses? If so, please list: _____

Please describe any previous eye or visual problems, and treatment your child has received (including glasses, vision therapy, patching, surgery, medications, etc).

Visual Complaints

- | | | |
|--|--|--|
| <input type="checkbox"/> Blurred Vision (far) | <input type="checkbox"/> Closes or covers an eye | <input type="checkbox"/> Burning, itching or tearing |
| <input type="checkbox"/> Blurred Vision (near) | <input type="checkbox"/> Tilts head | <input type="checkbox"/> History of wearing an eye patch |
| <input type="checkbox"/> Squinting | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> History of eye injury |
| <input type="checkbox"/> Crossed or wandering eye | <input type="checkbox"/> Double Vision | <input type="checkbox"/> History of eye surgery |
| <input type="checkbox"/> Difficulty tracking an object | <input type="checkbox"/> Eye strain or fatigue | |

(Please See Reverse)

EDUCATIONAL HISTORY

Current School: _____

Grade: _____

Has your child repeated any grades? Yes No If yes, which one? _____

Is your child receiving any tutoring, extra help, or special classes? Yes No

If yes, please describe. _____

Academic Complaints

Loss of place while reading and/or skipping words/lines
 Holds book too close
 Words moving or running together

Poor handwriting
 Frequent letter, number, or word reversals
 Poor spelling
 Poor, inefficient reading

Avoids reading
 Math difficulty: Facts/concepts
 Poor reading comprehension
 Difficulty copying from the board

Current Academic Levels

Please check appropriate box

	Above Grade	On Grade	Below Grade	Special Help
Reading				
Reading Comprehension				
Spelling				
Math				
Handwriting				

DEVELOPMENTAL HISTORY

Were there any complications with pregnancy or during birth? Yes No

If yes, please describe. _____

Was your child born prematurely? Yes No If yes, how soon? _____

Child's birth weight _____ Apgar Score _____

When did your child begin walking unassisted? _____

When did your child begin to say 2 to 3 word phrases? _____

Any speech problems now or in the past? Yes No Any problems with fine motor coordination? Yes No

Is your child clumsy? Yes No

Does your child enjoy, and participate in, activities such as drawing, colouring, puzzles, block play etc? (or with older children, did they previously?) Yes No

Other necessary information, please indicate below.
