Murrieta Creek
OPTOMETRY

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CHILD HISTORY FORM

(17 and under)

This more thorough history form is necessary for us to best administer the testing and determine a treatment program to meet your child's needs. Please fill out as completely as possible and return to us.

GENERAL INFORMATION:

Date: _____

Child's Name _____ Age: _____

Grade: _____ School: _____

Main concern or reason for visit: _____

Parent's/Guardian's Name(s): _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Last Full Visual Examination: ☐1 yr ☐2 yr ☐>2 yr ☐Never

Currently wearing glasses? ☐Yes ☐No If yes, for what? ☐near ☐far ☐both

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DEVELOPMENTAL HISTORY:

Is the child adopted? ☐Yes ☐No

Any prenatal problems with mother? ☐Yes ☐No If yes, please describe: _____

Full-term pregnancy? ☐Yes ☐No If no, at what week was the child born?: _____

Any complications before, during, or immediately following delivery? ☐Yes ☐No

If yes, please explain: _____

Oxygen given? ☐Yes ☐No If yes, for how long? _____

Did your child crawl? ☐Yes ☐No Age: _____ At what age did he/she walk?: _____ talk?: _____

Please list any noticeable developmental delays: _____

MEDICAL HISTORY:

Child's pediatrician: _____

Medications currently used: _____

Diagnoses/Conditions: _____

Allergies to medications: _____

Has there been any severe childhood illness, high fever, injury, or physical impairment? ☐Yes ☐No

If yes, please explain: _____

Has a hearing or speech deficiency been previously diagnosed: ☐Yes ☐No

If yes, please explain:_____

Any problems with headaches? ☐Yes ☐No

What causes the headaches? ☐reading ☐allergies ☐sinus problems ☐other_____

Do you feel your child is hyperactive, overactive, or normal for his/her age? _____

Has hyperactivity or attention deficit disorder (ADD/ADHD) been diagnosed? ☐Yes ☐No

If yes, any treatment? _____

Has your child been diagnosed on the autism spectrum? ☐Yes ☐No

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SCHOOL HISTORY:

Has your child been retained in school? ☐Yes ☐No If yes, what grade?_____

Has your child recently had a change in his/her grades in school? ☐Yes ☐No If yes, explain: _____

_____

Is your child having learning problems in school? ☐Yes ☐No Slight/Moderate/Severe?

If yes, in what areas? ☐reading ☐writing ☐spelling ☐language ☐phonics ☐math ☐all classes

Does your child like school? ☐Yes ☐No

Do you feel your child is working up to his/her potential? ☐Yes ☐No

Is he/she beginning to show emotional/behavioral responses to these struggles? ☐Yes ☐No

If yes, in what way? ☐rebellion ☐loss of self-esteem/self-confidence ☐aggressiveness ☐apathy ☐fear of failure ☐ giving up ☐accepting or believing he/she is dumb ☐other _____

Has educational testing been done? ☐Yes ☐No If yes, when? _____By whom? _____

Results: ☐no real problem found ☐problems but did not qualify for special education ☐learning disability noted and qualified for special education ☐diagnosed as dyslexia

Are there any behavior problems? At School:_____ At Home:_____

VISUAL RELATED SIGNS AND SYMPTOMS:

	Never	Once In a While	Sometimes	A lot	All the Time
Score	0	1	2	3	4
1. Headaches with near work					
2. Words run together					
3. Burning, itchy, watery eyes					
4. Skips/repeats lines					
5. Head tilt/closes an eye when reading					
6. Difficulty copying from chalkboard					

7. Avoids near work/reading					
8. Omits small words when reading					
9. Writes up/down hill					
10.Misaligns digits/column of numbers					
11. Reading comprehension down					
12. Holds reading material too close					
13.Trouble keeping attention on reading					
14. Difficulty completing assignments on time					
15. Always says "I can't" before trying					
16. Clumsy, knocks things over					
17. Does not use his/her time well					
18. Loses belongings/things					
19. Forgetful/poor memory					
Totals:					

Is there anything else you would like to tell us about your child so we can better get to know him/her before the testing?

IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH YOUR CHILD'S SCHOOL AND/OR OTHER PROFESSIONALS INVOLVED IN HIS/HER CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I agree to permit information from, or copies of, my child's examination records to be forwarded to my child's school, other health care providers, or insurance carriers upon their written request or upon the recommendation of TEMECULA CREEK OPTOMETRY when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I authorize TEMECULA CREEK OPTOMETRY to exchange information with my child's school and other professionals involved in my child's care, by means of my signature below. I hereby give my permission to TEMECULA CREEK OPTOMETRY to treat _____(Child's Name).

Signature of Parent/Guardian: _____ Date: _____

Relationship to patient: _____

This authorization shall be considered valid throughout the duration of treatment.