INDIANA VISION
Development Center, PC

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DATE _____

PATIENT FULL NAME _____DOB_____AGE_____
COMPLETE ADDRESS _____
PRIMARY PHONE _____ SECONDARY PHONE_____
HOMESCHOOL: YES ____ NO _____
SCHOOL NAME (if attending) _____ GRADE _____
PARENT'S EMAIL: _____

HOW DID YOU HEAR ABOUT US? _____

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PRESENT SITUATION: IN WHAT WAYS DOES PATIENT HAVE DIFFICULITY? _____
_____
_____

WHAT ARE COMPLAINTS? _____
_____

HAS ANYONE NOTICED AN EYE TURN IN_____ OUT____WHICH EYE? _____ WHEN? _____

DOES PATIENT HAVE ANY OF THE FOLLOWING, IF SO, WHEN?

HEADACHES YES _____ NO _____ WHEN? _____
BLURRED AT FAR YES _____ NO _____ WHEN? _____
BLURRED AT NEAR YES _____ NO _____ WHEN? _____
DOUBLE VISION YES _____ NO _____ WHEN? _____
EYES TIRED OR HURT YES _____ NO _____ WHEN? _____

HAS PARENT/GUARDIAN EVER NOTICED THE FOLLOWING?

HOLDING READING CLOSE YES _____ NO ____ WHEN? _____
HOLDING READING FAR YES _____ NO ____ WHEN? _____
CLOSING ONE EYE YES _____ NO ____ WHEN? _____
COVERING ONE EYE YES _____ NO ____ WHEN? _____
EYES OFTEN RED YES _____ NO ____ WHEN? _____
EXCESSIVE EYE RUBBING YES _____ NO ____ WHEN? _____
GET LOST IN BOOK YES _____ NO ____ WHEN? _____
READS WITH FINGERS YES _____ NO ____ WHEN? _____
READING IN BED YES _____ NO_____WHEN? _____
READING POSTURE YES _____ NO ____ WHEN? _____
UNABLE TO SEE DISTANCE YES _____ NO ____ WHEN? _____
BUMPS INTO OBJECTS YES _____ NO ____ WHEN? _____
POOR COORDINATION YES _____ NO ____ WHEN? _____
BOTHERED BY LIGHT YES _____ NO ____ WHEN? _____

(continue on back of form)

SCHOOL:
AGE AT TIME OF ENTRANCE_____Kindergarten _____ First_____
DOES PATIENT LIKE SCHOOL? ___ WAS GRADE REPEATED? _____ WHICH? _____
SCHOOL WORK: Average_____ Above Average_____ Below Average _____
SUBJECTS:
Easiest_____Difficult_____
HOW DOES PATIENT SPEND FREE TIME? _____

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DEVELOPMENTAL HISTORY:
PREGNANCY: Term _____ Preterm _____ Normal birth _____ C-Section _____
ANY COMPLICATIONS BEFORE/DURING/AFTER DELIVERY_____
_____
Did Child Crawl _____ Age _____ Age at Which Child Walked _____
Age of First Words _____ Age Began Using Sentences _____
When Fatigued, Child Will: Sag _____ Become Irritable _____ Excited _____
UNDER TENSION, IS THERE ANY PATTERN OF BEHAVIOR, THUMB SUCKING, ETC.: _____
_____

HEALTH HISTORY:
PHYSICIAN NAME / ADDRESS _____PHONE_____
LIST ANY MAJOR ILLNESSES: AGE MILD SEVERE
_____
_____
PRESENT MEDICATIONS:
_____
LIST ANY ALLERGIES:
_____

VISUAL HISTORY:
HOW LONG HAS DIFFICULTY BEEN NOTICED? _____
ANY HISTORY OF EYE SURGERY? _____ AGE_____

PREVIOUS VISUAL EXAMINATION:
REASON FOR EXAMINATION DOCTOR DATE RESULTS
_____
_____

FAMILY MEMBERS WHO HAVE HAD VISUAL ATTENTION AND WHY:
NAME AGE VISUAL SITUATION
_____
_____
_____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:
_____
_____
_____

As you complete this history questionnaire, you will recognize the thoroughness with which your child's problem will be considered. The office examination will take up enough time to permit a very complete optometric investigation of the problem. It is desirable to have both parents present during the examination. Your child's future deserves the fullest consideration that you as parents, and we in the office, can provide.

In order for us to keep costs down, payment is expected in full at the time of service.

Signature _____ **Date** _____