CENTURY CITY OPTOMETRIC CENTER

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10390 Santa Monica Blvd. Suite 320, Los Angeles, CA 90025

(Child)

Patient's Name:_____ **Date:** _____

Date of Birth:_____ **Age:**_____ **Sex: M F**

Grade:_____ **School:** _____

What is your main reason for coming here today? _____

_____

_____

Has your child been diagnosed or tested for ? ☐Autism Spectrum Disorder ☐ ADD/ADHD

☐Learning Disorder ☐Other_____

Is your child receiving any therapy (ie. speech/language, occupational therapy)?_____

VISION HISTORY

Date of your child's last eye examination:_____
Does your child wear glasses now? Y N ____ for distance only ____ for near only ____ full time
Has your child ever worn glasses? Y N
Does your child wear contacts lenses? Y N Any problems? _____
Has your child ever had vision therapy? Y N If yes, where? _____

HEALTH HISTORY: Please check the conditions that apply to your child or that run in your family.

	Child	Family		Child	Family
Allergies	☐	☐	Dry Eyes	☐	☐
Cancer	☐	☐	Cataracts	☐	☐
Drug Sensitivity	☐	☐	Eye Strain	☐	☐
Diabetes	☐	☐	Floaters/Spots	☐	☐
High Blood Pressure	☐	☐	Light Sensitivity	☐	☐
Elevated Cholesterol	☐	☐	Eye Surgery	☐	☐
Migraine/headaches	☐	☐	Turned eye	☐	☐
Thyroid	☐	☐	Lazy Eye	☐	☐
Heart Problem	☐	☐	Flashing Lights	☐	☐
Respiratory Disease	☐	☐	Retinal Detachment	☐	☐
Head Trauma	☐	☐	Glaucoma	☐	☐
Blindness	☐	☐	Color Blindness	☐	☐

How is your child's general health? _____ Date of last physical:_____

Is your child currently under a physician's care? Y N

Is your child regularly taking medications? Y N Please Specify_____

Allergies to Medications: _____

(continue on other side)

DEVELOPMENTAL MILESTONES

Full Term Pregnancy? Y N
Any complications before, during, or immediately following delivery? _____
Did your child crawl (stomach on floor)? Y N At what age? _____
Did your child creep (stomach off floor)? Y N At what age? _____
Did your child move around on all fours? Y N At what age? _____
At what age did your child walk? _____
Was your child active? Y N

Normal Birth? Y N
At what age did your child say his first word? _____
Was early speech clear to others? Y N
Is your child's speech clear now? Y N

SCHOOL-RELATED VISION PROBLEMS

How do you feel your child is doing in school? _____ Well _____ Below potential _____ Poorly

Please check the signs/symptoms that describe your child:

Reading:

Frequently loses place when reading	☐	Squints when looking up from reading	☐
Skips or re-reads words and lines	☐	Holds book extremely close	☐
Must re-read material to grasp meaning	☐	Reports that things look blurry	☐
Reverses words or letters (was for saw, b for d)	☐	Tires easily when reading	☐

School:

Has trouble seeing the board	☐	Gets tired quickly when doing homework	☐
Headaches after school work	☐	Short attention span	☐
Trouble copying from board to paper	☐	Is more than 1 year behind in reading skills	☐
Spends a long time doing homework	☐	Learns best through auditory (listens to learn)	☐

Behavior:

Acts up when asked to do school work	☐	Behavior has become a problem	☐
Class clown, "goofs off"	☐	Avoids work that includes reading	☐
Moody or depressed about school and life	☐	Has poor posture, slouches, or slumps in chair	☐

How does your child react to fatigue? ____Sags ____ Becomes Irritable ____ Becomes Excited ____Other
How does your child react to tension? _____Thumb sucking _____nail biting _____ Other
Other comments: _____

RECREATION AND LEISURE

In what recreational activities does your child participate? (Circle all that apply)

Read	Swim	Performing
Tennis	Soccer	Video games
Golf	Building models	Musical instruments
Baseball	Sew	Other: _____
Basketball	Dancing	

Do your child wear protective eyewear for their sport? Y N
Does your child watch television? Y N Hours per day _____
Does your child use a computer at school/home? Y N Hours per day _____
Does your child play video games? Y N Hours per day _____

Thank you for your help. The information in this personal history form is critical to your child's evaluation.