Date: _____/_____/_____

Child's Name: _____ **Date of Birth**: ____/ ____/ _____

Person completing this form: _____ **Relationship to the child**: _____

Has the child had a vision exam before?

[ ] No [ ] Yes If Yes, when?_____

Does the child wear glasses?

[ ] No [ ] Yes

Does the child wear contact lenses?

[ ] No [ ] Yes

Is the child currently taking any medications? [ ] NO [ ] YES
If YES, what? _____
Has the child had any allergic reactions to medications? [ ] NO [ ] YES
If YES, what? _____
Is the child presently diagnosed with any medical conditions? [ ] NO [ ] YES
If YES, what? _____

Child's Current Height _____ **Child's Current Weight** _____

Has the child ever had any of the following? If yes, please explain:

Eye surgery	[ ] No	[ ] Yes _____
Eye injury	[ ] No	[ ] Yes _____
Vision therapy or patching	[ ] No	[ ] Yes _____

Has anyone in the child's immediate family (parents, siblings) had the following?

Strabismus (Eye turns)	[ ] No [ ] Yes	If Yes, who? _____
Amblyopia ("Lazy eye")	[ ] No [ ] Yes	If Yes, who? _____
Childhood glaucoma	[ ] No [ ] Yes	If Yes, who? _____
Childhood cataracts	[ ] No [ ] Yes	If Yes, who? _____
High prescription	[ ] No [ ] Yes	If Yes, who? _____

Please complete this box if child is 0-5 years old

What was the length of the pregnancy for this child? _____
Were there any complications during the pregnancy or delivery of this child? If yes, please describe:
_____
The child's birth weight was: _____lbs _____oz.
Was oxygen provided to this child? [ ] No [ ] Yes If yes, how long? _____

Please complete box below if child is 5+ years old

Child's grade level_____
Does the child perform at grade level? [ ] No [ ] Yes

Does the child...

Has difficulty with attention or concentration?	[ ] No [ ] Yes
Easily lose his/ her place while reading?	[ ] No [ ] Yes
Avoid close work like reading or homework?	[ ] No [ ] Yes

Reviewed _____