Date: _____/_____/_____

Child's Name: _____DOB: _____

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? *Does the child wear contact lenses?*
[ ] *NO* [ ] *YES* [ ] *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? _____

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*

*Internal Use Only: History Obtained and Documented electronically by:*_____ *Date:* _____