



OPTOMETRICAL HISTORY

PLEASE PRINT

Child's name _____ Date of birth (MM/DD/YR) _____

Home phone _____ Parent's business phone _____

Parent's name _____

Address _____ City _____ Postal code _____

Health card # _____ Version code _____ Sex Male Female

Reason for today's appointment _____

FAMILY EYE HISTORY (please circle any if present or check here ____ if history not known)

Crossed eyes color vision problems lazy eye eyes shake constantly
 blindness eye related surgery cataract glaucoma other

FAMILY GENERAL HEALTH HISTORY (please circle any if present or check here ____ if history not known)

allergies (drug) high blood pressure frequent headaches heart problems thyroid
 allergies (other) low blood pressure genetic syndromes arthritis other
 diabetes stroke asthma epilepsy

CHILD'S PERSONAL HISTORY (please circle those which apply)

Appears to have crossed or lazy eye yes no
 Complains about blurred or double vision yes no
 School has identified a reading problem yes no
 School has identified or suspects a perceptual skills problem yes no
 Has child ever been hospitalized yes no
 Taking any medications yes no
 Any serious health-related problems since birth yes no

Other pertinent history or comments _____

PREGNANCY (please circle, fill in blank or check here ____ if history not known)

During pregnancy did mother smoke drink alcohol use medications
 Anesthetic used none epidural spinal block general
 Pregnancy was considered full term premature
 Labor considered normal difficult
 Any serious eye or general health
 Problems at birth yes no
 Mother's weight gained _____ Baby's weight at birth _____
 Mother's age _____
 Baby delivered natural cesarean

Date of child's last visual examination _____ by Dr. _____

Date of child's last medical examination _____ by Dr. _____

Date of child's last dental examination _____ by Dr. _____

PLEASE FILL OUT THIS FORM AND RETURN IT KINDLY TO THE FRONT DESK

THANK YOU