

PLEASE COMPLETE FOR PATIENTS UNDER 21 YEARS

Patient Name _____ **Birthday** _____ **Grade** _____

Home Address _____

City, Zip _____ Home Phone _____

Father's Name _____ Home Phone _____

Home Address _____ City, Zip _____

Employer _____ Work Phone _____

Mother's Name _____ Home Phone _____

Home Address _____ City, Zip _____

Employer _____ Work Phone _____

Name of School _____ City _____

Who is responsible for the child's account? _____

Who referred you to our office? _____

What is the reason for this visit? _____

Name of previous eye Doctor _____ Date of last exam _____

Have the eyes ever crossed? NO YES Date: _____

Any eye injuries or operations? NO YES Date: _____

WHICH OF THE FOLLOWING SYMPTOMS APPLY TO YOUR CHILD?

- | | |
|---|--|
| <input type="checkbox"/> Loses place when reading | <input type="checkbox"/> Distorted posture when reading and writing |
| <input type="checkbox"/> Uses fingers to keep place when reading | <input type="checkbox"/> Squints, rubs or covers eyes when reading |
| <input type="checkbox"/> Omits small words when reading | <input type="checkbox"/> Poor handwriting skills |
| <input type="checkbox"/> Confuses small or simple words | <input type="checkbox"/> Poor at sports, clumsiness |
| <input type="checkbox"/> Holds book too close when reading | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Avoids doing close work, reading & writing | <input type="checkbox"/> Daydreams during school/homework |
| <input type="checkbox"/> Reversals when reading (<i>was</i> for <i>saw</i>) | <input type="checkbox"/> Reversal when writing (<i>b</i> for <i>d</i>) |
| <input type="checkbox"/> Transposition of letters & numbers (<i>21</i> for <i>12</i>) | <input type="checkbox"/> Poor at spelling |
| <input type="checkbox"/> Does not perform up to his/her potential | <input type="checkbox"/> Poor self-esteem |

SCOLASTIC STANDING

Good Ave. Poor

READING ABILITY

Good Ave. Poor

SPORTS PERFORMANCE

Good Ave. Poor

What extracurricular activities does your child enjoy? _____

What medication (s) does the patient take? _____

Which of the following runs in the family?

Crossed or turned eye Lazy eye Learning disability Dyslexia

Heart Disease Diabetes Glaucoma/Eye Disease Seizure

Signature _____ Date _____