SNYDER EYE GROUP

Child Patient Heath History

Date:

Child's Name *(Last, First, M.I.):*	**Nickname:**	
Parent(s) Name *(Last, First, M.I.):*	**Child's Sex:**	**Age:** **DOB:**
Address:	**City:** **State:**	**Zip:**
Mother's Occupation:	**Home Phone:**	**Cell:**
Father's Occupation:		
School Name:	**Teacher's Name:**	**Nurses Name:**
Who referred you to our office?		

EYE HISTORY

Please state the major reason you would like your child examined:

Does your child have and/or complain of the following:

1. Headaches	☐ **No**	☐ **Yes**	☐ **Unknown**
2. Blurred distance vision	☐ **No**	☐ **Yes**	☐ **Unknown**
3. Blurred reading vision	☐ **No**	☐ **Yes**	☐ **Unknown**
4. Holds books closer than normal	☐ **No**	☐ **Yes**	☐ **Unknown**
5. Eyes hurt	☐ **No**	☐ **Yes**	☐ **Unknown**
6. Eyes tire	☐ **No**	☐ **Yes**	☐ **Unknown**
7. Double vision	☐ **No**	☐ **Yes**	☐ **Unknown**
8. Eye turn (crossed or walled eyed)	☐ **No**	☐ **Yes**	☐ **Unknown**
9. Blinks / rubs / tears	☐ **No**	☐ **Yes**	☐ **Unknown**

School

1. Does child like school?	☐ **No**	☐ **Yes**	☐ **Unknown**
2. Does child like teacher?	☐ **No**	☐ **Yes**	☐ **Unknown**
3. Is school satisfied with child's performance?	☐ **No**	☐ **Yes**	☐ **Unknown**
4. Are you satisfied with child's school performance?	☐ **No**	☐ **Yes**	☐ **Unknown**
5. Has a grade been repeated?	☐ **No**	☐ **Yes**	☐ **Unknown**

Directions: Please rate your child on the following items. Place a number to the right of the item which describes the child's school or home behavior(s).

1 – Always 2 – Frequently 3 – Occasionally 4 – Rarely 5 – Never 6 - Unknown

Hyperactive		**Easily distracted**	
Short Attention Span		**Easily frustrated**	
Impulsive		**Easily fatigues**	
Poor ability to organize work		**Indistinct speech**	
Awkward or clumsy		**Poor peer group relationships**	
Behavior problems		**Emotional problems**	
Confusion following a series of verbal instructions			
Variable school performance (from hour to hour or day to day)			
Reverses letters, words or numbers in reading			
Shows confusion about right, left or other directional orientations			

At what age in years and months did the child:

Speaks words clearly? _____ Start to crawl? _____ Walk unaided? _____

Which phrase describes the child's physical maturity? (circle number)

1. Physically immature for age 2. Average physical maturity for age 3. Advanced physical maturity for age

Rate the child's progress in the following subject using the scale below:

1. Below average 2. Average 3. Advanced

Reading		**Spelling**	
Arithmetic		**Writing**	
Drawing		**Physical Education**	

Have other family members had difficulties learning any of the above subjects?

Relation to child	Subject
1.	
2.	

Was there any history of pregnancy or birth complications? **Yes _____** **No _____**

If yes, please explain:

Has there been any severe childhood illness, high fever, injury or physical impairment? **Yes _____** **No _____**

If yes, please explain:

Has the child received a hearing test? **Yes _____** **No _____**

If yes, please explain:

VII. Additional (continued):

Has a speech deficiency been diagnosed? **Yes _____** **No _____**

If yes, please explain:

Has the child received a complete eye examination (other than a screening)? **Yes _____** **No _____**

Results: **Date of last exam:**

Has a visual problem been diagnosed? **Yes _____** **No _____**

If yes, please explain:

Does the child have any allergies? **Yes _____** **No _____**

If yes, please explain:

Is the child currently taking any medication or pills? **Yes _____** **No _____**

If yes, please explain:

Has there been any previous therapy for a learning problem? **Yes _____** **No _____**

If yes, please explain:

Type of therapy: **Dates:** **Results:**

Parent gives permission for the doctor to dilate the child's eye(s)? **Yes _____** **No _____**

Name of Insurance _____

Policy Number _____

Policy Member (Name insurance is under) _____ **DOB of Insured:** _____

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my medical status or condition.

_____ _____

Signature of parent or guardian **Date**