Citywide Eye Care

Pediatric Eye Exam History Form

Child's Full Name		Preferred Name	
Mother's Name	Occupation		Phone #
Father's Name	Occupation		Phone #
Medical History			
Pediatrician's Name / office			Phone #
Last Visit			
Medical diagnosis			
Medications		Allergies to Med:	
Developmental History			
Pregnancy		Full or Pre-mature	Birth weight:
Milestones			
At what month did your child perform the following:		Sat Crawled Walked Talked (ex: mama, dada)	
Neuro/psych evaluation		Yes or No	
If yes by whom?			Phone #
Occupational Therapy evaluation		Yes or No	
If yes by whom?			Phone #
Main reason for today's visit?			
Last eye exam			
How is your child performing compared to his/her peers?		Average Below Average Above Average	
Does your child report or do you believe your child had the any of the following			
Squints/ squeezes face		Yes or No	
Rubs eye excessively		Yes or No	
Pulls things close when reading		Yes or No	
Covers one eye / closes one eye		Yes or No	
Shows lack of interest in reading		Yes or No	
Reads with fingers to keep track of place		Yes or No	
Sometimes have blurry vision		Yes or No	
Vision seems worst at the end of the day		Yes or No	
Sometimes see things split into two		Yes or No	
Words run together when reading		Yes or No	
Headache after prolonged near work		Yes or No	
Family History			
Poor vison	Yes or No	Lazy eye	Yes or No
Eye turn	Yes or No	Learning issues	Yes or No
Blindness	Yes or No	Cancer	Yes or No