Covina Hills Optometric Group

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PARENT HISTORY FORM

Today's Date: _____

CHILD'S Name: _____ Date of Birth: _____ Grade:_____

Name of School: _____School Phone _____ Teacher(s):_____

Mother's Name: _____ Occupation: _____

Father's Name: _____ Occupation: _____

Brothers & Sisters (list ages): _____

MAJOR CONCERN:

• Briefly state your main concern & the main problem your child is experiencing: _____

_____

_____

_____

_____

•Who first noted the visual difficulties? _____ When? _____

•Did this difficulty occur suddenly? ❒ NO ❒ YES Did it seem related to any illness, accident, or specific incident? _____

• Has the problem gotten better or worse? _____

VISUAL HISTORY:

•Describe all previous vision care (including glasses, patching, vision exercises, medication or surgery)

_____

•Does your child report, or have you noticed, the following symptoms:

SYMPTOM	NEVER	SOMETIMES	FREQUENTLY	ALWAYS
Headaches when reading or concentrating on visual tasks				
Vision that blurs in & out of focus when reading or concentrating on visual tasks				
Eyes that "hurt," "sting," or "feel tired"				
Closing or covering one eye when reading or writing				
Difficulty concentrating when reading or studying				
Seeing "double vision" when reading or concentrating				
Words move, jump, swim, or seem to "float" on the page when reading or doing close work				
A "pulling" feeling in or around the eyes when reading or doing visual tasks				
Excessive rubbing or watering of the eyes when reading or doing close work				
Excessive blinking or squinting when concentrating				
Eyes are frequently red or bloodshot				
Gets sleepy when reading or doing visual tasks				
Taking more breaks than necessary when doing visual tasks				
Lose his/her place when reading				
Need to use a finger or marker when reading				
Skip or re-read words or entire lines when reading				

SYMPTOM	NEVER	SOMETIMES	FREQUENTLY	ALWAYS
Have difficulty finishing assignments in a timely manner				
Avoid reading or other close work				
Reverse letters (“b” for “d”) or numbers when reading or writing				
Transpose letters (“was” for “saw”) or numbers (“21” for “12”) when reading or writing				
Overlooks small details or misreads math symbols (“-“ for “+”)				
Have poor printing or handwriting				
Misalign numbers or columns when doing math problems				
Have difficulty copying written material				
Have a spelling problem				
Have trouble remembering what he/she has read				

DEVELOPMENTAL HISTORY:

- Child’s birth weight:_____Was your child premature?❒ NO ❒ YES→if yes, how many weeks:_____
- Describe any use of alcohol, drugs, medications, or cigarettes during pregnancy? _____

_____

- Describe any complications during pregnancy or at birth? _____
- Did your child have any early behavior or management difficulties (colic, tantrums, difficulty sleeping)? ❒ NO ❒ YES→if yes, describe: _____

- At what age did your child:
  - Crawl on “all fours” _____
  - Pull him/herself up to chairs & tables _____
  - Walk unassisted _____
  - Make his/her first speech sounds _____
  - Make his/her first words_____
    - Was early speech clear? ❒ NO ❒ YES Is speech clear now? ❒ NO ❒ YES
    - Describe any speech, language, or hearing evaluations or therapies _____
- Can your child:

Dress him/herself?	❒ NO ❒ YES	Zip zippers?	❒ NO ❒ YES
Tie bows?	❒ NO ❒ YES	Catch & throw a ball?	❒ NO ❒ YES
Lace shoes?	❒ NO ❒ YES	Ride scooters?	❒ NO ❒ YES
Button clothes?	❒ NO ❒ YES	Ride a bicycle?	❒ NO ❒ YES

- Has your child had any occupational or physical therapy evaluations or therapies? ❒ NO ❒ YES→if yes, when & results: _____

GENERAL HEALTH & BEHAVIOR:

- Describe any severe illnesses, high fevers, injuries, or physical impairments: _____

_____

- Has your child had ear infections? ❒ NO ❒ YES→if yes, how often & treatment given: _____

_____

- Does your child have any history of:

Food allergies	❒ NO ❒ YES	Eye injuries	❒ NO ❒ YES
Medication allergies	❒ NO ❒ YES	Head injuries	❒ NO ❒ YES
Environmental allergies	❒ NO ❒ YES	Spinal injuries	❒ NO ❒ YES
Asthma	❒ NO ❒ YES	Seizures	❒ NO ❒ YES

• Has your child ever had a neurological evaluation? ❒ NO ❒ YES→if yes, when & results: _____
_____
• Is your child currently taking any medications? ❒ NO ❒ YES→if yes, type & purpose: _____
_____

• List your child's usual hours of sleep: _____ Does he/she sleep soundly? ❒ NO ❒ YES
• Does your child have periods of significant fatigue? ❒ NO ❒ YES→if yes, when:_____
• Does your child have periods of significant stress? ❒ NO ❒ YES→if yes, when:_____
• How does your child react to fatigue or stress? _____

• What hand does your child use? ❒Right ❒Left ❒Both Has "handedness" ever changed? ❒NO ❒YES
• Is your child good with his/her hands for her age? ❒ NO ❒ YES Do activities such as building sets, coloring, cutting, & puzzles keep his/her attention? ❒ NO ❒ YES
• Does your child like to participate in sports or other outdoor activities? ❒ NO ❒ YES→if yes, what: __
_____
• What are your child's special interests? _____
• Does your family read a lot? _____
• Describe any family history of:
Reading, writing or spelling difficulties: _____
Hyperactivity or attention problems: _____

EDUCATION: ✏

• At what age did your child begin: Nursery school: _____ years
Kindergarten: _____ years
First Grade: _____ years
• Has your child ever repeated a grade? ❒ NO ❒ YES→if yes, which: _____
• Has your child ever had any educational evaluations (psychological, speech, special education, RSP etc)?
❒ NO ❒ YES→if yes, when, by whom, & result: _____
• Does your child receive any special services from the school (therapy, reading support, adaptive PE etc)?
❒ NO ❒ YES→if yes, what & how often: _____
_____
• Is your child in a specialized classroom setting or program (RSP, Special Ed, GATE)? ❒ NO ❒ YES→if yes, what & how often: _____
• Does your child receive tutoring? ❒ NO ❒ YES→if yes, for what & how often: _____
_____
• How do you feel your child is getting along in school? _____
If there is difficulty at school, what do you think is the reason? _____
What is his/her best subject?_____ Easiest subject?_____ Hardest subject?_____
• What does your child report about school or school work? _____
• Has the teacher reported anything about your child's schoolwork? _____

• Does your child like school? ..... ❒ NO ❒ YES
Does your child like his/her teacher? ..... ❒ NO ❒ YES
Does your child attend school regularly? ..... ❒ NO ❒ YES
Are you satisfied with your child's performance? ..... ❒ NO ❒ YES
Is the school satisfied with your child's performance? ..... ❒ NO ❒ YES
Is his/her performance up to potential? ..... ❒ NO ❒ YES
Does his/her performance reflect the effort put into his/her work? ..... ❒ NO ❒ YES
Does your child read as well as others in his/her grade? ..... ❒ NO ❒ YES
Does your child read as well as brothers/sisters? ..... ❒ NO ❒ YES