Los Gatos Eye Care

DEVELOPMENTAL HISTORY

DATE_____

Child's Name _____ Date of Birth ____/____/____
LAST FIRST MIDDLE INITIAL

Mother's Name _____ Father's Name _____
LAST FIRST LAST FIRST

Address _____ Sex □ Male □ Female Age _____
STREET NAME

_____ Social Security Number _____
CITY STATE ZIPCODE

Home Telephone _____ Cell Telephone _____

Work Telephone _____ Email _____

Medical Insurance Carrier _____ PPO / PIO / HMO

How did you hear about us? Live in neighborhood / VSP website / lgeyecare website / friend or co-worker _____

Date of Last Exam ____/____/____ Problems Noted _____

_____

Grade _____ Teacher's Name _____

School Address _____

Pediatrician's Address _____ Pediatrician's Name _____

_____ Pediatrician's Phone _____

Please state the reason for your visit _____

_____

General History: Is there a history of pregnancy or birth complication? □ Yes □ No

Please Explain _____

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

Please Explain _____

Has the child received a hearing test? □ Yes □ No If yes, what date? ____/____/____

Has a hearing of speech deficiency been previously diagnosed? □ Yes □ No

Has there been any previous therapy for learning difficulties or visual/speech problems? □ Yes □ No

Please Explain _____

_____

_____

Physical Development: At what age in years and months did the child:

Start to crawl _____ Start to walk _____ Speak words clearly _____

School Progress: Rate your child's progress in the following subjects:

1 - Very Good 2 – Good 3 – Satisfactory 4 – Not Satisfactory

_____ Reading _____ Spelling _____ Writing _____ Math _____ Art _____ Physical Education _____ Other

General Behavior

Are there any behavior problems at…

School □ Yes □ No

Home □ Yes □ No

What causes these problems? _____

_____

Visual History

Last Eye Exam ____/____/____ Doctor's Name _____

Results _____

Were glasses prescribed? □ Yes □ No

Are they worn? □ Yes □ No

When? _____

Continued on next page…

Glasses

Does child wear glasses? □ Yes □ No

No

a) For: □ Near □ Distance □ Both

b) □ Single Vision □ Bifocals
□ Progressive □ Trifocals

c) Any Problems? _____

d) Do you wear sunglasses? □ Yes □ No

e) Are your sunglasses prescription? □ Yes □ No

Contacts

Does child wear contacts? □ Yes □

Reason for stopping _____

a) □ Full Time □ Part Time □ Rarely

b) Type of Contacts?
□ Daily Wear □ Extended Wear
□ Soft Toric □ Gas Permeable

c) What cleaning solution do you use? _____

d) If your child does not wear contacts, is he/she interested at this time? □

VISION	YES	NO	?
1) Headaches	___	___	__
2) Blurry distance vision	___	___	__
3) Blurry reading vision	___	___	__
4) Holding books closer	___	___	__
5) Eyes hurt	___	___	__
7) Double vision	___	___	__
8) Eyes get tired	___	___	__
9) Eye turns in or out	___	___	__
10) Blinks excessively	___	___	__
11) Covers one eye	___	___	__
12) Turns head to one side	___	___	__
13) Watery eyes	___	___	__

Comments:

_____
_____
_____
_____

SCHOOL PERFORMANCE	YES	NO	?
1) Is your child having problems in school?	___	___	__
2) Does your child need to sit close to the board?	___	___	__
3) Does your child like the teacher?	___	___	__
4) Is school satisfied with child's performance?	___	___	__
5) Are you satisfied with your child's performance?	___	___	__
6) Do grades really show child's ability?	___	___	__
7) Does child lose their place while reading?	___	___	__
8) Does child misread words that are known?	___	___	__

Comments on your child school performance:

_____
_____
_____
_____
_____
_____
_____

Please rate the following items:

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

___ Hyperactive
___ Easily Distracted
___ Short Attention Span
___ Easily Frustrated
___ Impulsive
___ Easily Fatigued
___ Confusion following a series of verbal instructions
___ Reverses letters, words, numbers in reading (from hour to hour, day to day)
___ Poor Ability to Organize Work
___ Indistinct Speech
___ Awkward or Clumsy
___ Poor Peer Group Relations
___ Behavior Problems
___ Emotional Problems
___ Variable School Performance
___ Shows confusion about right, left or other directional orientations

FAMILY MEDICAL HISTORY

EYE DISEASES

	Yes	No	Who		Yes	No	Who
Amblyopia (Lazy Eye)				Color Blindness			
Eye Tumor				Glaucoma			
Blindness				Macular Degeneration			
Cataract(s)				Retinal Detachment			

SYSTEMIC DISEASES

	Yes	No	Who		Yes	No	Who
Arthritis				High Cholesterol			
Cancer				Stroke			
Diabetes				Kidney Disease			
Heart Disease				Lupus			
High Blood Pressure				Thyroid Disease			

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PATIENT MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
Allergies (seasonal)			Glaucoma			Sandy or Gritty Feeling		
Excessive Weight Changes			Cataract(s)			Strabismus (Crossed Eyes)		
Ear, Nose, Throat			Macular Degeneration			Blurred Vision at Distance		
High Blood Pressure			Retinal Detachment			Blurred Vision at Near		
Asthma/Breathing Problems			Color Blindness			Distorted Vision (halos)		
Stomach Problems			Glare/Light Sensitivity			Double Vision		
Arthritis/Osteoporosis			Tired Eyes			Floaters or Spots		
Skin Problems			Amblyopia			Fluctuating Vision		
MS/Seizures			Burning Eyes			Loss of Vision		
Anxiety/Depression			Dryness			Loss of Side Vision		
Kidney Problems			Excess Tearing/Watering					
Diabetes			Eye Pain/Soreness					
Thyroid Problems			Itching					
Anemia/Blood Disorders			Mucous Discharge					
Lyme Disease			Ptosis (drooping eyelid)					
HIV/Herpes			Redness					
Cancer (What type?):								

Eye injuries, infections or surgeries (including LASIK) _____

Any other surgeries _____

Medications that cause reactions or sensitivities _____

Specific Allergies _____

Current Medications (including vitamins & herbal supplements) _____

_____

Thank you for taking the time to help our office personalize your eye care. Your answers will help guide our doctors and staff to your specific needs. We look forward to seeing you for your examination and please feel free to let us know if you have any other needs or concerns we have not addressed.

_____ _____

Doctor's Signature Date

SYMPTOM CHECKLIST

NAME _____ **DATE**_____

Please complete this questionnaire. After each symptom listed, check the number that best describes how often you experience that particular problem.
0 = never, 1 = seldom, 2 = occasionally, 3 = frequently, 4 = always.

		0	1	2	3	4
1.	Blurred vision at near					
2.	Double vision					
3.	Headaches associated with near work					
4.	Words run together when reading					
5.	Burning, stinging, watery eyes					
6.	Falling asleep when reading					
7.	Vision worse at the end of the day					
8.	Skipping or repeating lines when reading					
9.	Dizziness or nausea associated with near work					
10.	Head tilt or closing one eye when reading					
11.	Difficulty copying from the chalkboard					
12.	Reversals of letters like “b's” + “d” or “p's” + “q's”					
13.	Avoidance of reading and near work					
14.	Omitting small words when reading					
15.	Writing uphill or downhill					
16.	Misaligning digits in columns of numbers					
17.	Reading comprehension declining over time					
18.	Inconsistent/poor sports performance					
19.	Holding reading material too close					
20.	Short attention span					
21.	Difficulty completing assignments					
22.	Saying “I can't” before trying					
23.	Avoiding sports and games					
24.	Difficulty with hand tools – scissors, keys					
25.	Inability to estimate distaces accurately					
26.	Tendency to knock things over on desk or table					
27.	Misplaces or loses papers, objects, belongings					
28.	Car sickness/motion sickness					
29.	Forgetful, poor memory					
30.	Very sensitive to lighting (too light or dark) when reading					

For Doctor's Use Only

TOTAL SCORE: _____
NOTES:
_____
_____
_____
_____

_____ _____
Doctor's Signature Date