Lambert Fick
BEHAVIOURAL OPTOMETRISTS
LAMBERTFICK.CO.ZA

CHILD'S VISION AND DEVELOPMENT HISTORY

For parents

This information will help us determine what examination routines will best apply to your child's visual needs.

Name of child _____ Child's birth date _____
Name of school _____ Present school grade _____
Teacher's name _____ Referred by _____
Parents name _____
Address _____

PRESENT SITUATION:

1. In your opinion, what is the child's problem? _____
   _____
2. How does your child indicate his/her problem? _____
   _____
3. Does your child report any of the following:
   Headaches: Yes / No When? _____
   Blurry vision: Yes / No When? _____
   Blur at distance: Yes / No When? _____
   Double vision: Yes / No When? _____
   Eyes "hurt" or "tired": Yes / No When? _____

VISUAL HISTORY:

1. How long has the difficulty been noticed? _____
2. Last vision examination (date) _____
3. Reason for last examination _____
4. Family vision problems: Mother / Father / Siblings _____
   _____
5. Has your child ever received vision therapy? Yes / No _____

SCHOOL:

1. Age entering pre-school _____ First grade: _____
2. Does your child like school? Yes / No Teacher? _____
3. Has a grade been repeated? Yes / No Which grade _____
4. Have there been any school difficulties? _____
5. Is school work average / above average / below? _____
6. Which subject seem particularly easy? _____
7. Which subjects seem particularly difficult? _____

BEHAVIOUR:

Have you or anyone else ever noted the following?
(Answer no/yes, if yes note when)

1. Hold reading too close? _____
2. Close or cover one eye? _____
3. Eyes frequently red? _____
4. Excessive eye rubbing and/or excessive blinking? _____
5. Frequent sties? _____
6. Getting lost in a book? _____
7. Tilting head while reading? _____
8. Inability to see distant objects _____
9. Bumping into objects? (poor general co-ordination) _____
   _____
10. Bothered by light? _____
11. Poor penmanship? _____

DEVELOPMENT HISTORY:

1. Full term pregnancy? _____ Normal Birth? _____
2. Did your child crawl? _____ All fours? _____Age? _____
3. At what age did your child walk? _____ Speak? _____
4. As an infant was your child active? _____ Now? _____
5. When tired does your child become irritable or excited? _____
6. Any nervous habits (thumb sucking, nail biting)? _____
7. List any severe illness your child may have had? _____

NUTRITION:

Please give a brief description of the nutritional philosophy in the child's home.
_____

PERSONALITY:

Please give a brief description of your child's personality _____
_____
_____
_____
_____