Los Gatos Eye Care

DEVELOPMENTAL HISTORY

Child's Name:_____D.O.B_____
Mother's Name:_____Father'sName:_____
Address: _____
Home Telephone: _____Work/ Cell Telephone: _____Email: _____
Medical Insurance Carrier: _____PPO / PIO / HMO

How were you referred to our office? Live in neighborhood / VSP website / lgeyecare website /friend or co-worker_____
Date of last examination: _____Problems noted: _____
_____

Grade: _____Teacher's Name: _____
School Address:_____

Pediatrician's Name and Address:_____
Pediatrician's Phone Number: _____
Please state the reason of 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 ___ Date: _____ NO ___
Has a hearing or speech deficiency been previously diagnosed? YES ___ NO ___
Is the child currently taking any medications? YES ___ NO ___
If yes, please list the medications and explain their purpose: _____
_____
Has there been any pervious therapy for learning difficulties or visual or speech problems? YES ___ NO ___
Please explain: _____
_____

GENERAL HEALTH CONDITION

Yes	No		Yes	No		Yes	No	
		Fever			Respiratory (asthma, emphysema)			Skin Neurological (acne, cancer)
		Weight Loss			Gastrointestinal			Endocrine (diabetes, thyroid)
		Ears, Nose, Throat			Kidney			Blood/Lymph (cholesterol/anemia)
		Cardiovascular (high blood pressure, etc.)			Muscles, Bones, Joints (arthritis)			Allergic/Immunologic

EYE HISTORY

Yes	No		Yes	No		Yes	No	
		Glare/Light Sensitivity			Itching			Blurred Vision Distance
		Headaches			Mucous Discharge			Blurred Vision Near
		Tired Eyes			Drooping Eyelid			Distorted Vision (halos)
		Amblyopia (Lazy Eye)			Redness			Double Vision
		Burning			Sandy or Gritty Feeling			Floaters or Spots
		Dryness			Crossed Eyes			Fluctuating Vision
		Excess Tearing/Watering			Infection of Eye or Lid			Loss of Vision
		Eye Pain or Soreness						Loss of Side Vision

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

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
___ Shows confusion about right, left or other directional orientations
___ Poor Ability to organize work
___ Indistinct Speech
___ Awkward or clumsy
___ Poor Peer Group Relations
___ Behavior Problems
___ Emotional Problems
___ Variable School Performance (from hour to hour, day to day)

Signature: _____Relationship to child: _____ Date: _____

Thank you for taking the time to help our office personalize your eyecare. Your answers will help guide our doctors and staff

to your specific needs. We look forward to seeing for your examination and feel free to let us know if you have any other needs or concerns we have not addressed.

Los Gatos Eye Care Staff

_____ _____
Doctor Signature Date