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Pediatric History Questionnaire

Child's Name _____ Date of Birth _____ Today's Date: _____
Home address: _____ Home phone : _____
Parent's name: _____phone: _____ email: _____
Parent's name: _____phone: _____ email: _____
Who can we thank for referring you? (If self-referred, how did you hear about us?) Name: _____

The reason my child is being examined today is_____
How long have you noticed this? _____ Family history of same problem? _____
Last eye exam was on: _____Where: _____ Results: _____
Glasses: Yes No / Age 1st Worn _____ Contact lenses: Yes No

Have you noticed or does your child complain of any of the following?

	Never	Rarely	Sometimes	Often	Always
Blurry Distance Vision					
Blurry Reading Vision					
Blurry Computer Vision					
Closes or covers one eye					
Seeing double					
Rubs eyes					
Reads for only a short time					
Poor reading comprehension					
Holds books/print very close					
States that eyes are tired					
Headaches when reading					
Head moves when reading					
Loses place when reading					
Skips lines when reading					
Uses finger to keep place when reading					
Difficulty recognizing letters, words or simple shapes					
Difficulty distinguishing the main idea from insignificant details					
Trouble learning basic math concepts of size, magnitude and position					
Trouble with mathematical concepts					
Poor recall of visually presented material					
Sloppy handwriting and drawing					
Can't stay in lines					
Poor copy skills					
Can respond orally but not in writing					
Trouble learning right and left					
Reverses letters and words					

(please continue to next page)

Birth and Development History

How long was the pregnancy? _____ months Birth weight _____ lbs. _____ oz.
Any complications during pregnancy? Yes, No _____
Any alcohol/drug use during pregnancy? Yes No _____
Any complications during delivery? Yes No _____
Any complications after birth? Yes No _____
Labor/delivery was: natural _____induced _____Caesarian _____ Forceps used _____ Oxygen used _____
Mother's age at child's birth: _____ Father's age at child's birth: _____
My child is: natural _____ adopted _____ foster _____ other _____
Medication prescribed during first year of life: none ____ med: _____
Age when child first: sat _____ crawled _____ walked _____ talked (2-3 words) _____

Health History

Physician's name_____ Date of last physical _____
Medications: _____ Reason for taking: _____
_____ _____
_____ _____
Allergies to medications: _____

Academic History

What School does your child attend? _____ Grade? _____
Age when started kindergarten? _____ Has a grade ever been repeated? Yes No ____grade
Easiest subject _____ Most difficult subject _____
Does your child like school? Yes No
Does your child like his/her teacher? Yes No
Is your child in any special education classes? Yes No
Is your child on a special education plan? Yes No
Is your child receiving any tutoring? Yes No
Is your child above/average/ below grade level for reading? (circle one)
Is your child above/average/ below grade level for math? (circle one)
Has your child undergone any of the following testing/treatment?

Educational	Yes	No	Neurological	Yes	No	Psychological	Yes	No
Occupational	Yes	No	Speech	Yes	No	Physical	Yes	No

Explain_____

SCREEN TIME: Computers/ Television/Tablets/iPad/Phones

Academic time:	Days per week_____	Hours per day____	Distance from eyes to screen_____
Recreational:	Days per week_____	Hours per day____	Distance from eyes to screen_____
Social:	Days per week_____	Hours per day____	Distance from eyes to screen_____

Release of medical information - authorization to send reports to the following:

1. Name: _____
   Address: _____ City: _____ Zip: _____
2. Name: _____
   Address: _____ City: _____ Zip: _____

I authorize Dr. Vasilakos to release and share information regarding my testing and or treatment program with the above listed professionals.

Parent signature: _____ Date: _____