CHILDREN WITH SPECIAL NEEDS OCULAR AND MEDICAL HISTORY QUESTIONNAIRE

Child's Name ______________________________ Date of Birth________________ Date of Exam ___________________

Whom may we thank for the referral of your child?

Name ____________________Address____Phone __________________

1. The primary reason my child is here today for an eye exam is:

☐ general checkup - no problems ☐ rule out visual problems seen in other family members
☐ eye turns inward ☐ child squints a lot ☐ rubs eyes a lot
☐ eye turns outward ☐ eyes do not seem to focus ☐ Other - please explain below

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2. What is your child's developmental diagnosis?

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3. Is your child currently taking any medications? ☐ No ☐ Yes-List names & reasons:______________________________

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4. Is you child allergic to any medications? ☐ No ☐ Yes-List:____

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5. My child is: ☐ natural ☐ adopted ☐ foster ☐ other ______________

6. REVIEW OF SYSTEMS

Does your child have or has your child had: Explain:

Surgery/Hospitalization ☐ Yes ☐ No

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Cardiovascular/heart problems ☐ Yes ☐ No

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High blood pressure, murmur, other

Breathing problems ☐ Yes ☐ No

____

Asthma, shortness of breath, other

Gastrointestinal problems ☐ Yes ☐ No

____

Food problems, diarrhea, vomiting, other

Endocrine problems ☐ Yes ☐ No

____

Diabetes, thyroid, growth, other

Urinary problems ☐ Yes ☐ No

____

Pain/discomfort, blood in urine, other

Skin problems ☐ Yes ☐ No

____

Unusual rashes, excess dryness, other

Musculoskeletal problems ☐ Yes ☐ No

____

Juvenile rheumatoid arthritis, other

Neurological problems ☐ Yes ☐ No

____

High fever, seizures, balance, other

Psychiatric/Social problems ☐ Yes ☐ No

____

Any behavior problems, other

General growth/development ☐ Normal ☐
Delayed____

7. Mother's age when child was born: _________

8. How long was the pregnancy? _____________weeks

9. During the pregnancy of this child, which, if any, of the following occurred:

☐ excessive nausea ☐ use of alcohol ☐ staining
☐ use of drugs ☐ toxemia ☐ use of megadoses of vitamins
☐ severe illness ☐ injury by falling ☐ regular obstetrical care
☐ poor pre-natal care ☐ trauma ☐ poor nutrition
☐ smoking ☐ poor hygiene ☐ prescribed medication
☐ other, please explain

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10. Labor during delivery lasted _____________hours.

11. Labor ☐ was induced ☐ was not induced

12. Type of delivery: ☐ natural ☐ Caesarean –emergency ☐ scheduled C-section ☐ forceps and/or suction utilized

13. Were there problems during delivery? ☐ No ☐ Yes - Please explain: ______________________________

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14. This child's birth weight was _____________lbs _____________ounces

15. Apgar scores were (only if known)______________@ 1 minute and ______________ @ 5 minutes

16. Immediately after birth (before leaving the hospital) my child was:

☐ doing well, requiring no special medical treatment ☐ received oxygen
☐ In need of medical attention ☐ placed in neonatal ICU
☐ placed in an incubator for ___________ days ☐ having Rh problems
☐ jaundiced ☐ allergic

☐ other, please explain ____

17. Was any medication prescribed during the first year of life? ☐ No ☐ Yes-Explain______________________________

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18. Is child's development normal in these areas:**(PLACE A ✓ YES AND AN X FOR NO.)**

Sitting _______ Creeping_______ Speech _______ Crawling _______ Walking ________ Emotional ________

19. At present my child is enrolled in:

☐ preschool program ☐ Early intervention program ☐ Resource room in school

☐ visually limited school program ☐ program for the blind and visually handicapped

☐ Mainstreamed in a regular classroom with supplemental therapies outside the classroom

☐ Other (Please explain)

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20. List all previous evaluations done on your child and resultant diagnoses. (If more space is needed use the other side.)

Doctor or Institution Date Type of Evaluation Results

A.

____

____

B.

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C.____

____

D.

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21. My child is presently receiving the following therapies:

Therapy	In Program	Privately at home	Times/week	How long in therapy?
Occupational	☐	☐	________________	________________
Physical	☐	☐	________________	________________

Speech	☐	☐	________________	________________
Special Education	☐	☐	________________	________________
Vision Services	☐	☐	________________	________________

Other, please specify

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22. FAMILY HISTORY (Check all appropriate boxes)

	Near-sighted (Myopia)	Far-sighted (Hyperopia)	Astigmatism	Amblyopia (Lazy Eye)	Eye Turn (Strabismus)	Color Vision Defect	Genetic or Familial disorde
Father	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐
Brother/Sister	☐	☐	☐	☐	☐	☐	☐
Uncle/Aunt	☐	☐	☐	☐	☐	☐	☐
Grandparent	☐	☐	☐	☐	☐	☐	☐