BINOCULAR VISION CLINIC HISTORY FORM

Please fill out this form carefully.
Please return it to our office prior to your appointment in the envelope provided. Thank you.

Patient's Name: _____ Male ☐ Female ☐ # of siblings: _____

Birthday: _____/_____/_____ Age: _____ yr _____ mo Grade: _____ Email: _____

Mailing Address: _____ Phone: _____

School Name: _____ Teacher Name: _____ Address: _____

Primary Care Physician: _____ Phone: _____

Parent/Guardian(s) Name: _____ Occupation: _____ Phone: _____

Parent/Guardian(s) Name: _____ Occupation: _____ Phone: _____

Were you referred to our clinic? Yes ☐ No ☐

If yes, whom may we thank for this referral? _____ Relationship to referral source: _____

Mailing Address: _____ Phone: _____

Please state the major reason you would like your child examined: _____

_____

VISION (Please place a check in the appropriate box)

	Never (0)	Rarely (1)	Occasionally (2)	Frequently (3)	Always (4)
Do your eyes feel tired when reading or doing close work?					
Do your eyes feel uncomfortable when reading or doing close work?					
Do you have headaches when reading or doing close work?					
Do you feel sleepy when reading or doing close work?					
Do you lose concentration when reading or doing close work?					
Do you have trouble remembering what you have read?					
Do you have double vision when reading or doing close work?					
Do you see the words move, jump, swim, or appear to float on the page when reading or doing close work?					
Do you feel like you read slowly?					
Do your eyes ever hurt when reading or doing close work?					
Do your eyes ever feel sore when reading or doing close work?					
Do you feel a "pulling" feeling around your eyes when reading or doing close work?					
Do you notice the words blurring or coming in and out of focus when reading or doing close work?					
Do you lose your place while reading or doing close work?					
Do you have to re-read the same line of words when reading?					
Do you experience blurred distance vision?					
Do you have double vision at distance?					
Do you have an eye turn? (crossed or wall-eyed)					
Do you cover one eye when reading or doing close work?					
Do you hold reading material closer than normal?					
Do you have eye pain?					
Do you have a head tilt?					
Do you have motion sickness / car sickness?					
Do you have difficulty judging distances?					
Do you have difficulty hitting / judging moving targets during sports?					

GENERAL HEALTH

	No	Yes	If yes, please explain:
Any pregnancy or birth complications?			
Any severe childhood illness, high fever, injury, or physical impairment?			
Any diagnosed visual problems?			Date of last eye exam:
Any diagnosed hearing impairment?			Date of last hearing test:
Any allergies?			
Any medications and/or vitamins?			Please list, including purpose, dosage, duration of treatment:
History of previous (or current) therapy for learning, vision, occupational, physical, and/ or speech difficulties?			Please list, including type of therapy, duration, and results:

BEHAVIOR

	Never	Rarely	Occasionally	Frequently	Always
Hyperactive					
Easily distracted					
Short attention span					
Easily frustrated					
Impulsive					
Easily fatigued					
Poor ability to organize work					
Indistinct speech					
Awkward or clumsy					
Behavior problems					
Emotional problems					
Confusion following a series of verbal instructions					
Variable school performance (from hour to hour/ day to day)					
Reverses letters, words, or numbers in reading					
Reverses letters, words, or numbers in writing					
Shows confusion about right or left					
Shows confusion about directional orientation					

SCHOOL INFORMATION

Resources/Accommodations	No	Yes	If yes, since when and for what areas?
504 Plan in place?			
IEP (Individualized Education Program) in place?			

PROGRESS: (Please rate your child's progress in the following subjects)

	Above grade level	At grade level	Below grade level	What specific areas or academic skills is your child experiencing difficulty? Comments:	Any family member with learning difficulties? Please indicate subject and relationship to child.
Reading					
Spelling					
Writing					
Arithmetic					
Art					
Music					
Phys. Education					
Other? Please list:					

Signature: _____ Date: _____

Relationship to patient: _____ Parent/Guardian email address: _____

Thank you! ☺