MILL VALLEY OPTOMETRY
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415.381.2020

Developmental History

Date__________________ E-mail ____

Name ____________________________________ Date of birth ____________ Age _____ Sex M ☐ F ☐

Address____________________________________ City____________________ State_____ Zip_______

Responsible Party: ______________________________ SS #______________________________________

Telephones: Home #____________________ Wk. # _________________ Cell # ____________________

Employer/School: ___________________________ Occupation/Grade: ____________________________

Vision insurance: VSP ☐ Eye Med ☐ Other ___________________________________

Subscriber Name ___________________________ SS #________________ DOB_______________

Medical Insurance: ____

Subscriber Name ___________________________ SS #________________ DOB_______________

Please list other people living in your home:

Name_____________ Relationship________ Age _____ Name_____________ Relationship________ Age _____

Name_____________ Relationship________ Age _____ Name_____________ Relationship________ Age _____

Date of last eye exam: _________________________ Name of Doctor: ____________________________

Do you wear glasses? ☐ Yes ☐ No Contact lenses? ☐ Yes ☐ No Brand _____________How many years?____

What is the reason for today's visit? Who referred you? ______________________________

____

____

OCULAR HISTORY

Do you currently have any vision-related issues?

☐ Blurry vision ☐ Double vision ☐ Amblyopia/Lazy eye ☐ Flashes of light ☐ Floaters in vision
☐ Headaches/Migraines ☐ Dizziness/balance ☐ Crossed Eye ☐ Halos in vision ☐ Light sensitivity
☐ Head tilt/face turn ☐ Losers attention easily ☐ Motion sickness ☐ Discomfort with 3D movies
☐ Poor reading comprehension ☐ Poor tracking/eye movement ☐ Other ______________________

Do you currently experience any of the following?

☐ Dry or scratchy eyes ☐ Burning eyes ☐ Red eyes ☐ Tired/fatigued eyes ☐ Itchy eyes
☐ Eye infection ☐ Watery eyes ☐ Eye injury or trauma ☐ Eye pain/irritation

Do you currently have any motor-related issues?

☐ Poor motor control ☐ Clumsy/stumbles easily ☐ Trouble catching ball ☐ Other ______________________

ACADEMIC/BEHAVIORAL HISTORY

Please rate your child from 1 to 5: *1 = Always* *2 = Frequent* *3 = Occasional* *4 = Rarely* *5 = Never*

Impulsive behavior	_______	Trouble finishing work on time	_______	Anxiety about school	_______
Difficulty sitting still	_______	Reads below grade level	_______	Poor handwriting	_______
Confuses right and left	_______	Trouble with verbal instructions	_______	Poor spelling skills	_______
Poor ability to organize work	_______	Skips lines while reading	_______	Working below potential	_______
Re-reads sentences often	_______	Has difficulty with math	_______	Enjoys School	_______
Attention issues in class	_______	Falls asleep when reading	_______	Holds book very close	_______

MEDICAL HISTORY

Pediatrician's name: ____________________ Last visit: ____________________

List all prescription medications and any vitamins/supplements/over-the-counter medications your child is taking.

(Use separate sheet if necessary)

Medication____________________Dose__________ Reason____________________

Medication____________________Dose__________ Reason____________________

Medication____________________Dose__________ Reason____________________

List any medications he/she is allergic to: ____________________

Have you or a member of your family had a history of the following?

	SELF	Family member (list)			
Sinus, ears, nose	☐	________	Neurologic (seizures)	☐	________
Bones, joints, arthritis	☐	________	Strabismus/Amblyopia	☐	________
Respiratory (lungs, breathing)	☐	________	High Cholesterol	☐	________
Stroke	☐	________	Chronic Fatigue	☐	________
Heart disease	☐	________	Diabetes	☐	________
Thyroid Disease	☐	________	Digestive disease	☐	________
Cataracts	☐	________	Macular Degeneration	☐	________
Glaucoma	☐	________	Retinal detachment	☐	________
Keratoconus	☐	________	Cancer	☐	________

DEVELOPMENTAL HISTORY (for patients under 18)

Length of pregnancy: ____________ Type of delivery: ☐ Natural ☐ C-section ☐ Forceps/vacuum ☐ Anesthesia

Child's birth weight: ____________ Child is: ☐ Biological ☐ Adopted ☐ Foster ☐ Other ________

During pregnancy of this child, did any of the following occur?

☐ Toxemia ☐ Trauma ☐ Injury by fall ☐ Severe illness ☐ Prescribed medication

☐ Tobacco use ☐ Alcohol use ☐ Illicit drug use Please explain: ____________________

Has your child ever been diagnosed with a Developmental Delay? ☐ Autism ☐ ADD ☐ ADHD ☐ Other________

How is your child performing compared to others his/her age: ☐ Above average ☐ Average ☐ Below average

Does your child like to read? ☐ Yes ☐ No

Has a grade been repeated? ☐ Yes ☐ No

How well is your child's spoken vocabulary? ☐ Above average ☐ Average ☐ Below average

Has your child undergone any of the following testing / treatment / therapy?

Educational	☐ Yes ☐ No	Neurological	☐ Yes ☐ No	Psychological	☐ Yes ☐ No
Occupational	☐ Yes ☐ No	Speech / auditory	☐ Yes ☐ No	Physical	☐ Yes ☐ No
Tutoring	☐ Yes ☐ No	Vision Therapy	☐ Yes ☐ No	Other	☐ Yes ☐ No

Describe: ____________________

____

____

Please describe your child's strengths and weaknesses in school:

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____

Please give a brief description of your child's personality, including interests:

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