Marcy Rose, O.D., F.C.O.V.D.

WELCOME TO OUR OFFICE

Patient's Name: ________________________________ Nickname: ________________________

Birth Date:	Age (Years):	(Months):	Female ☐	Male ☐
Name of School:		Grade:	Teacher:	
Address:		City/State:		Zip:

Illnesses, head/neck injuries, high fevers, etc.:

Condition	mild **Severity** 1	2	3	4	5	6	7	8	9	severe 10	**Complications**	**Age__**

Ear Infections Yes / No	How Often?:	**Hay Fever** Yes / No	Time of year?:
Asthma Yes / No	How Often?:	**Other**	

Has your child or any one in your family been treated for the following? (Please CIRCLE which applies):

Eyes	Self / Family Member	Neurological	Self / Family Member
Ear, Nose, Throat	Self / Family Member	Endocrine Disorder	Self / Family Member
Cardiovascular health	Self / Family Member	Genitourinary	Self / Family Member
Respiratory	Self / Family Member	Skin	Self / Family Member
Gastrointestinal health	Self / Family Member	Musculoskeletal	Self / Family Member
Psychiatric	Self / Family Member	Hematological/Lymphatic	Self / Family Member
Allergic/Immunologic	Self / Family Member	High Blood Pressure	Self / Family Member
Diabetes	Self / Family Member	Learning Disability	Self / Family Member
"Cross"/"Wall" eye	Self / Family Member	Amblyopia (lazy eye)	Self / Family Member
Chromosomal Imbalance	Self / Family Member	Epilepsy or Seizures	Self / Family Member
Thyroid Condition	Self / Family Member	Multiple Sclerosis	Self / Family Member
Glaucoma	Self / Family Member	Autism Spectrum Disorder	Self / Family Member
Macular Degeneration	Self / Family Member	ADD	Self / Family Member
ADHD	Self / Family Member	Other	Self / Family Member
Adopted: Yes / No **Unknown biological medical history:** Yes / No **Known biological medical history:** Yes / No			

Has a **neurological** evaluation been performed? Yes / No By whom?
Results and recommendations:
Has a **psychological** evaluation been performed? Yes / No By whom?
Results and recommendations:
Has an **occupational/speech/physical therapy** evaluation been performed? Yes / No
By whom?
Results and recommendations:
Has an **educational** evaluation been performed? Yes / No By whom?
Results and recommendations:

DEVELOPMENTAL HISTORY

	Yes	No		Yes	No		Yes	No
Full term			Insufficient Oxygen			Forceps		
Normal Delivery			ROP			Birth Injuries		

Complications before, during or immediately following delivery? ____

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Birth Weight:	Apgar Score at Birth:	Apgar after 10 minutes:

	Yes	**No**	**Age/Description**
Did your child crawl (stomach on floor)?			
Did your child creep (on all fours)?			
Was your child overly active?			
Was there ever a reason for concern over your child's general development?			

At what age did your child walk? ___________________________

Coordination:

☐	Poor General Coordination	☐	Falls, trips often	☐	Difficulty/Dislikes:
☐	Clumsy	☐	Poor rhythm	☐	Manipulating Small objects
☐	Careless	☐	Spills	☐	Pencil/Crayon/Cutting use
☐	Bumps into objects	☐	Poor Eye/hand Coordination	☐	Tying/Buttoning
☐	Poor Hopping	☐	Avoids Sports	☐	Building
☐	Poor Skipping	☐	Poor running	☐	Poor fine motor coordination
☐	Difficulty with sequential tasks	☐	Difficulty /dislikes ball sports	☐	
☐	Poor ability: alternating movement	☐	Avoids trying new movements	☐	
	Kicking: foot used? R / L		**Writing:** hand used? R / L		**Throwing:** hand used? R / L

Speech:

Did your child start speaking around (circle one): 12 months 15 months 18 months Other:
Concern about clarity of speech to others? Yes / No If so, explain:
Any other speech/language concerns? Yes / No If so, explain:

VISUAL HISTORY

Is this your child's first complete vision exam? Yes / No If **no**, previous doctor's name:	
Date of last exam:	Reason for previous exam:
Previous results/recommendations:	
Does your child currently wear glasses, contact lenses or other optical devices prescribed? Yes / No	
If yes, what?:	
If/When are they used?:	
If not used, why?:	

Reason for today's evaluation?: **Routine check**: Yes / No **Special concern:** Yes / No

Please explain: ____

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Are any other professionals specifically concerned about your child's vision?: Yes / No

Please explain: ____

Please check all of the following that apply to your child:

Headaches		Motion Sick		Light sensitivity	
Blurred Far Vision		Car Sick		Flashing lights	
Blurred Near Vision		Squinting		Floaters	
Double Vision		Dry eyes		Frequent Styes	

Eyes ache		Red eyes		Eyes itching	
Eyes burn		Frequent blinking		Frowning	
Eyes tired		Excessive rubbing		Eye Surgery:	
Eyes tearing/watering		Covers an eye		Crossed Eye	
Dizziness		Closes an eye		Wall eyed	

Please check all of the following that apply to your child while READING:

Loses place		Head turns when reading		Avoids reading	
Skips lines		Reads slowly		Reads out loud/lip reads	
Skips/omits words		Head close to the book		Tires easily	
Rereads lines		Reverses letters		Short attention span	
Uses a finger as a marker		Reverses words		Prefers being read to	
Uses other as a marker		Likes to read		Better remembered if heard	
Tilts head when reading		Sub vocalizes when reading silently		Poor comprehension	
Difficulty recognizing same word on different page		Decreased Comprehension over time			

Please check all of the following that apply to your child while WRITING:

Avoids		Difficulty copying		Writes/Prints poorly	
Tilts head when writing		Reverses numbers		Writes neatly but slowly	
Reverses letters		Reverses words		Frequent erasing	
Writes slowly		Responds better orally		Knows material, struggles with tests.	

Please check all of the following that apply to your child with MATH:

Trouble memorizing facts		Slow to complete work		Poor number sense	
Trouble learning new concepts		Skips problems by accident		Trouble with sequencing patterns	
Trouble with word problems					

SCHOOL HISTORY

Age at time of entrance to: **Pre-school:** **Kindergarten:** **First Grade:**

Does your child like school? Yes / No Has your child changed schools often? Yes / No

Has your child repeated a grade/grade(s)? Yes / No

Does your child show frustration when doing school work? Yes / No

Has your child had special tutoring, therapy or remedial services? Yes / No

If **yes**, please explain:

Does your child have to spend more time than anticipated to achieve these levels? Yes / No

Do you and the teachers feel your child is achieving up to his/her potential? Yes / No

Frequent absences? Yes / No If **yes**, why?

CURRENT ACADEMIC LEVELS

	Above Grade Level	At Grade Level	Below Grade Level	Special Help	Actual Current Level
Reading					
Reading Comprehension					
Spelling					
Math					
Handwriting					
Other:					

Favorite subject: ___________________________ Least favorite subject: ___________________________

Other school difficulties: ____

BEHAVIORAL CONCERNS

Problems at school? Yes / No If **yes**, explain?

Problems at home? Yes / No If **yes**, explain?

Problems with impulsivity? Yes / No	Problems with child in constant motion? Yes / No
Other:	

FAMILY AND HOME

Please indicate which adult(s) he/she lives with:

Please indicate which adult(s) he/she lives with?							
Mother	☐	Father	☐	Grandmother	☐	Aunt	☐
Step Father	☐	Step Mother	☐	Grandfather	☐	Uncle	☐
Foster Parents	☐	Other	☐		☐		
Has your child ever been through a traumatic family situation?				Yes	☐	No	☐
If **yes**, explain:							
Does your child seem to have adjusted? Yes / No							
Was counseling/therapy undertaken? Yes / No		If **yes**, is it on-going? Yes / No					

Does your child have a difficult time getting along with others (ie: Parents, siblings, friends, etc.)? Yes / No
If **yes**, explain:

Family history of learning disabilities:

Did your child's father or anyone on his/her father's side of the family have a learning problem? Yes / No
If **yes,** who/to what extent? ____

Did your child's mother or anyone on his/her mother's side of the family have a learning problem? Yes / No
If **yes**, who/to what extent? ____

Do/Did any of the other children in the family have a learning problem? Yes/ No
If **yes**, who/to what extent? ____

Is there anything else you would like us to know about your child? ____________________

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Report for a consultation:
Please fill out the form as completely as possible. We will be unable to send copies of the report to anyone with incomplete information. Please include your child's teacher or school nurse, Occupational Therapist, Speech Therapist, Physical Therapist, Tutor, etc.

Name:	Title:	
Address:	City/State:	Zip:
Name:	Title:	
Address:	City/State:	Zip:
Name:	Title:	
Address:	City/State:	Zip:
Name:	Title:	
Address:	City/State:	Zip:

Please sign below, giving North Park Vision Center, P.C. your authorization to send reports and/or speak to the individuals listed above.

Print Name:	Date:
Signature:	Relationship to patient: