Plymouth Family Optometry LLC

212 S. Meadow Rd, Unit 5C, Plymouth, MA 02360
Dr. Ryan Racette, Optometrist

Pediatric History Form

Prenatal/Birth/Postnatal History

Your child is (choose one): Biological Adopted Foster Other _____

Duration of pregnancy _____ weeks

Were there any problems during pregnancy? Yes No If yes, please specify _____

Type of delivery? Vaginal C-section

How many days did your child need oxygen after delivery? _____ days

Were there any complications immediately following the birth of your child? Yes No

If yes, specify _____

Your child's weight was: _____lbs _____oz

Your child's APGAR score was? At birth _____ After 10 minutes _____

Developmental History

Did your child start sitting at approximately 5-8 months of age? Yes No

Did your child start crawling at approximately 5-8 months of age? Yes No

Did your child start walking at approximately 11-15 months of age? Yes No

Did your child start speaking at approximately 12-22 months of age? Yes No

Has your child been diagnosed with emotional disorders? Yes No

Has your child had uncommon childhood diagnoses or hospitalizations? Yes No

Please explain: _____

Is your child developmentally delayed? Yes No

Does your child have favorite toys, games, songs? Yes No

Is your child fearful of certain things? Yes No

Did your child have any significant issues during their infant/toddler years? Yes No

Please explain: _____

Does your child have epilepsy and/or a history of seizures? Yes No

Do you wish to provide us additional information about your child or have any other concerns? Yes No

_____

Previous Tests/Evaluations

Has your child had an IEP evaluation? Yes No

Has your child had a psycho-educational evaluation? Yes No

Has your child had a WISC IV/IQ evaluation? Yes No

Has your child had other tests or evaluations? Yes No

Previous Vision Care

Has your child ever worn eye glasses? Yes No If yes, when did he/she start wearing them? _____

Has your child ever worn contacts? Yes No If yes, when did he/she start wearing them? _____

Has your child ever worn an eye patch? Yes No If yes, when and how often? _____

Has your child ever used atropine eye drops? Yes No If yes, when _____

Has your child ever had an eye surgery? Yes No If yes, when and for what reason? _____

Has your child ever taken other eye medications? Yes No If yes, when and for what reason? _____

_____

Has your child ever received vision therapy? Yes No If yes, when? _____

Academic History/Status

What school does your child currently attend? _____

What is your child's current grade in school? _____

Has your child ever repeated a grade in school? Yes No

In your opinion, what is your child's favorite subject? _____

In your opinion, what is your child's least favorite subject? _____

What is your child's reading level? Above Average Average Below Average

What is your child's math level? Above Average Average Below Average

What is your child's overall school performance? Above Average Average Below Average

Do you believe that your child is performing to their potential? Yes No

Is your child currently receiving occupational therapy? Yes No

Is your child currently receiving physical therapy? Yes No

Is your child currently receiving math tutoring? Yes No

Is your child currently receiving reading tutoring? Yes No

Time Spent on Sports Daily _____

Time Spent on Near Tasks Daily _____

Time Spent on Screen Viewing Daily (i.e. TV, computer, other electronic devices) _____

Signature of Parent or Legal Guardian _____ Date _____/_____/_____

College of Optometrists in Vision Development Quality of Life Outcomes Assessment (COVD-QOL)

Patient's Name _____ Date: _____

Check the column that best represents the occurrence of each symptom

	NEVER	ONCE IN A LONG WHILE	SOMETIMES	A LOT	ALWAYS
1. Headaches with near work					
2. Words run together reading					
3. Burn, itch, watery eyes					
4. Skips/repeats lines reading					
5. Head tilt/close one eye when reading					
6. Difficulty copying from chalkboard					
7. Avoids near work/reading					
8. Omits small words when reading					
9. Writes up/down hill					
10. Misaligns digits/columns of numbers					
11. Poor Reading comprehension					
12. Holds reading too close					
13. Trouble keeping attention on reading					
14. Difficulty completing assignments on time					
15. Always says "I can't" before trying					
16. Clumsy, knocks things over					
17. Does not use his/her time well					
18. Loses belongings/things					
19. Forgetful/poor memory					