ITHACA EYECARE OPTOMETRY

Name:_____**DOB:**_____/_____/_____
Address:_____
Phone:_____**Email:**_____@_____.com

Present Situation

How did you hear about us?	
Briefly explain the reason for visit:	
At which age did you notice the problem?	
Has the problem become? (circle)	Better / worse / same
List any previous treatment for this problem?	

School History

Name of school		Grade		Contact Person	
Does your Child like school?	Yes/No	Does your child like his or her teacher?	Yes/N o		
School work is_____? (circle one)	Above average	Average	below average		

Which classes are at or above grade level? (circle)	Language Arts	Math	Music	PE	Science	Social Studies
Which classes are below grade level? (circle)	Language Arts	Math	Music	PE	Science	Social Studies

Does your child like to read?	Yes	No
Do you feel your child is working up to his/ her potential?	Yes	No
Does your child prefer to be read to rather than reading on his/ her own?	Yes	No
Does your child attend any special classes? If yes explain:_____	Yes	No
Does you child have an IEP? If yes explain:_____	Yes	No

Additional Testing History

Educational	Yes	No	Results:
Hearing	Yes	No	Results:
Neurological	Yes	No	Results:
Psychological	Yes	No	Results:
Speech	Yes	No	Results:

Medical History (check and explain those that apply)

	Cancer		Digestive
	Ear/ Nose/ Throat		Kidney
	Sinus Problem		Genitourinary
	Neuro		Muscle/ Bone/ Arthritis
	Psychological		Skin
	Cardiovascular		Diabetes/ Endocrine
	High Blood Pressure		Cholesterol
	Respiratory / Asthma		Immune
	Environmental Allergies		Food Allergies

Please list all medications: (oral and/or eye drops)

Medication	**Dosage**	**For**
List Allergies to Medications:		

Family History

Condition	**Y**	**N**	**Who**
Cancer Type:			
Diabetes Mellitus			
Hypertension			
Hyper Thyroid			
Cataracts			
Macular Degeneration			
Glaucoma			
Other			

Child Development History

Was your child: (circle one)	Full term / Premature (under 37 weeks)
Complications at birth (circle one)	Toxemia / Pre-eclampsia/ Trauma/ Alcohol Use/ Drug Use / Severe Illness
Explanation of above	
When did your child walk?	Early (before 11 months) / On Time / Late (after 14 months)
Other development History	

Head Injury History

Has your child had a head injury / concussion	Yes / No
Were they hospitalized?	Yes/ No
Please explain how it happened	

Visual Symptoms
Instructions: Please circle the item that best matches your symptoms. Please rate each symptom.
How often does each occur? (circle a number)

	Never	Seldom	Occasional	Frequently	Always
Headaches with near work	0	1	2	3	4
Words run together while reading	0	1	2	3	4
Burning itchy watery eyes	0	1	2	3	4
Skipping/ repeating lines while reading	0	1	2	3	4
Tilting head or closing one eye while reading	0	1	2	3	4
Difficulty copying from a chalkboard	0	1	2	3	4
Avoiding near work or reading	0	1	2	3	4
Omitting small words while reading	0	1	2	3	4
Writing uphill or downhill	0	1	2	3	4
Misaligning digits/ columns of numbers	0	1	2	3	4
Poor reading comprehension	0	1	2	3	4
Holding books or near work very close to eyes	0	1	2	3	4
Short attention span with near work	0	1	2	3	4
Difficulty completing assignments	0	1	2	3	4
Saying “I can’t” before even trying something	0	1	2	3	4
Clumsiness and knocking things over	0	1	2	3	4
Poor use of time	0	1	2	3	4
Losing belongings or misplacing things	0	1	2	3	4
Forgetting things	0	1	2	3	4
Double vision (if yes: Near/ far? Direction? side to side, up & down, diagonal)	0	1	2	3	4

Have the following vision problems been diagnosed?

Amblyopia	Yes/ No
If yes describe treatment (patching)	

Strabismus (eye turn)	Yes/ No
If yes at what age diagnosed	
Which direction does the eye turn	In, Out, Up, Down
Which eye turns	Left, Right, Both
When doe the eye turn	always, rarely, beginning of day, end of Day, when tired
Has your child had treatment for strabismus	Yes/ No explain:

Hobbies/ Interests	

If your child **has had any kind of head injury**, the following symptoms checklist should be filled out

Visual Symptoms Instructions: Please circle the item that best matches your symptoms today. Please rate each symptom. How often does each occur? (circle a number)	**Never**	**Seldom**	**Occasional**	**Frequently**	**Always**
Blurry vision in distance	0	1	2	3	4
Blurry vision when reading	0	1	2	3	4
Fluctuating / inconsistent vision	0	1	2	3	4
Headaches	0	1	2	3	4
Photophobia (light sensitivity)	0	1	2	3	4
Hyperacusis (hearing sensitivity)	0	1	2	3	4
Double vision	0	1	2	3	4
Loses place while reading	0	1	2	3	4
Poor memory, forgetting	0	1	2	3	4
Attention / concentration difficulties	0	1	2	3	4
Visual memory difficulty	0	1	2	3	4
Vision is worse at the end of the day	0	1	2	3	4
Re-reads reading material in order to comprehend	0	1	2	3	4
Difficulty with eye tracking	0	1	2	3	4
Eye Fatigue	0	1	2	3	4
Mental Fatigue	0	1	2	3	4
Physical fatigue	0	1	2	3	4
Special disorientation	0	1	2	3	4
Night vision worse then day vision	0	1	2	3	4
Dizziness	0	1	2	3	4
Flashes of light	0	1	2	3	4
Irritability	0	1	2	3	4
Emotional distress / anxiety	0	1	2	3	4
Balance issues	0	1	2	3	4
Vertigo/ nausea	0	1	2	3	4
Car/ motion sickness	0	1	2	3	4
Sleep disturbances	0	1	2	3	4
Disordered thinking	0	1	2	3	4
Walking difficulties	0	1	2	3	4
Poor depth perception	0	1	2	3	4