

**INDIANA UNIVERSITY SCHOOL OF OPTOMETRY
PEDIATRIC/BINOCULAR VISION SERVICES MEDICAL HISTORY**

Today's Date	
Child's Full Name (Last, First, and MI)	
Child's Birth Date	

In order to provide the best possible care for your child, please answer the following questions. Thank you.

Prenatal/Birth/Postnatal History

01. Your child is: Natural Adopted Foster Other
02. What was the duration of your pregnancy? _____ weeks
03. Were there any problems during your pregnancy? Yes No
04. What was the type of delivery? Vaginal C-Section
05. How many days did your child spend in the hospital after delivery? _____ days
06. Did your child need oxygen after delivery? Yes No
07. How many days did your child need oxygen after delivery? _____ days
08. Were there any complications immediately following the birth of your child? Yes No
09. Your child's weight was: _____ lbs. _____ oz.
10. Your child's APGAR score was (please circle)? 1 2 3 4 5 6 7 8 9 10

Developmental History

11. Did your child start sitting at approximately 5–8 months of age? Yes No
-
12. Did your child start crawling at approximately 5–8 months of age? Yes No
-
13. Did your child start walking at approximately 11–15 months of age? Yes No
-
14. Did your child start speaking at approximately 12–22 months of age? Yes No
-
15. Has your child been diagnosed with emotional disorders? Yes No
-
16. Has your child had uncommon childhood diagnoses or hospitalizations? Yes No
-
17. Is your child developmentally delayed? Yes No
-
18. Do you have other concerns about your child (i.e., ADHD, autism, etc.)? Yes No
-
19. Does your child have favorite toys, games, or songs? Yes No
-
20. Is your child fearful of certain things? Yes No
-
21. Did your child have any significant issues during their infant/toddler years? Yes No
-
22. Does your child have epilepsy and/or a history of seizures? Yes No
-
23. Do you wish to provide us with additional information about your child? Yes No

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Previous Tests/Evaluations

24. Has your child had an IEP evaluation? Yes No
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25. Has your child had a psycho-ed evaluation? Yes No
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26. Had your child had a WISC IV/IQ evaluation? Yes No
-
27. Has your child had other tests or evaluations? Yes No

Previous Vision Care

28. Has your child ever worn eye glasses? Yes No
-
29. Has your child ever worn contacts? Yes No
-
30. Has your child ever worn an eye patch? Yes No
-
31. Has your child ever used atropine eye drops? Yes No
-
32. Has your child ever had an eye surgery? Yes No
-
33. Has your child ever taken other eye medications? Yes No
-
34. Had your child ever received vision therapy? Yes No

Academic History/Status (please answer the following questions if your child is in school)

35. What school does your child currently attend? _____
36. Your child's current grade in school? _____
37. Has your child ever repeated a grade in school? Yes No
38. In your opinion, what is your child's favorite subject? _____
39. In your opinion, what is your child's least favorite subject? _____
40. What is your child's reading level? Above Average Average Below Average
-
41. What is your child's math level? Above Average Average Below Average
-
42. What is your child's overall school performance? Above Average Average Below Average
-
43. Do you believe that your child is performing to their potential? Yes No
-
44. Is your child currently receiving occupational therapy? Yes No
-
45. Is your child currently receiving physical therapy? Yes No
-
46. Is your child currently receiving math tutoring? Yes No
-
47. Is your child currently receiving reading tutoring? Yes No
-
48. Is your child currently receiving vision therapy? Yes No

Signature of Patient or Legal Guardian _____

Print Name _____ Date _____