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

25. Has your child had a psycho-ed evaluation? ☐ Yes ☐ No

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 _____