



WELCOME TO OUR OFFICE

Our Patient ID: _____

The development of your child's vision is affected by certain illnesses, as well as the family history. This questionnaire will provide information needed to complete a visual record, and aid us in determining how your child's vision has developed.

Date: _____

Child's Last Name: _____ Title: Mast / Miss / _____

First Name: _____ Known As (if different): _____

Person to Receive Mail on Child's Behalf (if required): _____

Address: _____
(postal) _____ Postcode: _____

Phone: Hm: _____ Wk (parent/guardian): _____ Mb: _____

Birth Date: _____ Age: _____ Sex: M / F School: _____ Grade: _____

Medicare No: _____ Exp: _____ Veterans Affairs Card: Gold White Orange

Some Health Insurance Funds require extra information. Please advise us so that we can provide these details for you:

Private Fund (Name: _____)

Medical Practitioner: _____ May we send a report to your GP? Yes No

Hobbies/Interests: _____ Sports: _____

What recommended you to our practice?

- Mailing Newspaper Radio Television Website Yellow Pages Doctor
 Friend School Location Reputation Other _____

HEALTH HISTORY - PARENT/GUARDIAN TO COMPLETE

PLEASE ANSWER TO THE FOLLOWING QUESTIONS:

Is the child presently under a doctor's care? Y N

PRESENT SITUATION

Does The Child Ever Report:

- Headaches Y N
- Blurred vision Y N
- Eyes "hurt" or "tired" Y N
- Double Vision (seeing two) Y N

Have You Noticed:

- Excessive eye rubbing Y N
- Holding reading close Y N
- Frowning or squinting Y N
- Reversing words / letters / numbers Y N
- Confuses Right and Left Y N
- Short attention span Y N
- Bumping into objects or tripping over Y N
- Poor general co-ordination / clumsy Y N
- Closes or covers one eye Y N
- Large pupils in bright light Y N
- Untidy or crowded writing Y N

GENERAL HEALTH

- Any allergies Y N
- Any significant injuries Y N
or past illnesses Y N
- Currently on medications Y N

DEVELOPMENTAL HISTORY

- Full term pregnancy Y N
- Normal birth Y N
- Did The Child...
 - Crawl before walking Y N
 - Crawl in any unusual way Y N
 - Start walking at expected age Y N
 - Start talking at expected age Y N
 - Have any speech problems Y N

FAMILY HISTORY

- Any unusual eye conditions in the family Y N
- Any diabetes in the family Y N

SCHOOL HISTORY

- Does child like to read Y N
- Is the child's school work...
 - Better than expected Y N
 - As expected for ability Y N
 - Below what is expected Y N

VISUAL HISTORY

- Child's eyes ever crossed Y N
- Last Visual Exam
 - Approx Date: _____
 - By Whom: _____
- Name of Person
Completing This Form: _____