6 – 18 YEAR-OLD HISTORY FORM

Patient's Name________________________ Date__________ Grade: ________
Accompanying adult(s) name(s)_______________________________________
Relationship to child:____
Were you referred here by anyone? ___________________________________

Please fill this out with your child

Do you have prescription glasses? Yes No
If yes, how often do you wear them? Always Sometimes Never

Answer ALL of the following questions. If you have glasses or contacts, answer the questions as they apply when you are wearing them…

Like to read	Yes	No	Like to be read to	Yes	No
Blurred vision at near	Yes	No	Headaches	Yes	No
Reverse letters/numbers	Yes	No	Skips words/loses place	Yes	No
Double vision	Yes	No	Hold material very close	Yes	No
Slow focusing near to far	Yes	No	Rub eyes a lot while reading	Yes	No
Read slowly	Yes	No	Close/cover one eye	Yes	No
Working below potential	Yes	No	Tilt head frequently	Yes	No
Use finger as a marker	Yes	No	Avoid near tasks	Yes	No
Attention Deficit Disorder	Yes	No	Learning Disability	Yes	No

Words seem to move or float on the page Yes No
Eye strain/fatigue with reading Yes No….If yes, after how many minutes? _________
Any family members with learning problems, lazy eye, vision therapy? Yes No

Has your child received any additional help at school or in a private setting such as:

Speech therapy	Yes	No	Occupational therapy	Yes	No
Physical therapy	Yes	No	Vision therapy	Yes	No
Special education	Yes	No	Tutoring	Yes	No

Repeated Grade Yes No….If Yes: What grade(s) __________________
Reading at grade level? Yes No….If No: Below Above

Comprehension	Poor	Fair	Good
Math	Poor	Fair	Good
Spelling	Poor	Fair	Good
Handwriting	Poor	Fair	Good

Additional comments or concerns ____
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