Vision Associates
See the Very Best

CHILD'S HEALTH HISTORY QUESTIONNAIRE
PLEASE PRINT

Child's Name:_____ **Date of Birth:**_____
Parents'/Guardians' Names:_____
Mother's Age at time of Birth:_____ **Father's Age at time of Birth:**_____
Parents'/Guardians' occupations:_____

Pediatrician:_____
Address:_____ Phone Number:_____

Pregnancy and Birth History
Pregnancy length (in weeks)?_____
Complications during pregnancy:_____
Complications during delivery:_____
Birth weight:_____ APGAR Score:_____ Was Oxygen used? Yes No

Allergies
Medications:_____
Foods:_____

Child Development
Please list any known developmental delays:_____
_____

Eye Health History:
Please note if your child has experienced any of the following:
Eye turn: YES NO If yes: IN OUT
Right Eye Left Eye Both Eyes

Eye surgery: YES NO If yes: Type:_____
Date:_____

Please circle any of the following conditions your child has experienced
Eye Redness Eye Rubbing Squinting Watery Eyes White Pupil Swollen Eyes

Please list any other concerns you have about your children's eyes:_____
_____

Child's Health History:
Please list any health concerns regarding your child_____
_____
Has your child ever had a high fever? Yes No If yes: at what age?_____ temperature_____
Has your child had any head injuries or other serious injuries or accidents? (please list age at event)_____
Please list any surgical procedures your child has had (other than eye surgery)

Has your child been diagnosed with ADHD? YES NO

Have any family members been diagnosed with the following eye conditions? (please list relationship to patient)

Glaucoma_____ Amblyopia (Lazy Eye)_____
Blindness_____ Cataracts_____ Vision Therapy_____
Any other eye disorders_____

Have any family members been diagnosed with the following health conditions? (please list relationship to patient)

Diabetes:_____ Cancer (please list type):_____
Asthma/Breathing Problems:_____
Heart Conditions:_____
Learning Disability:_____

Does anyone in the family wear glasses? (Please list relationship, age of first prescription (if known), and reason for glasses:_____

Child's School History

Grade in School_____
Does your child have an IEP?_____ If yes, what concerns are addressed in the IEP?_____

Please circle child's classroom setting:

Public School: Traditional Modified
Private School: Traditional Modified
Home School

School your child attends (optional)

_____

Child's favorite subject:_____
Child's least favorite subject:_____