Developmental History

Steven L. Goedert, O.D.
Curtis Newcomb, O.D.
Janet Newcomb, O.D.

Date ________________________________

PERSONAL

Child's Full Name ____ Birthdate ______________________________

Street Address ____ City, State, Zip __________________________________

Telephone Number ____________________________________ Physician Name _________________________________

School Name _______________________________ Grade _________ Teachers Name ______________________________

Spouse or Parents Name ____

Social Security # ____________________ Insurance __________________Whom do we thank for referral? ______________

How did you learn about our office? Phone Book ____ Friend or Family ____ Newspaper ____ Other ____

PRESENT SITUATION

Why do you feel your child needs a visual examination? ____

Is there any evidence from the school or psychological test that some visual difficulties may be present? Yes ___ No ___

If so, please explain: ____

Does your child report any of the following?

Headaches? Yes ____ No ____ When? _________________ Blurred Vision? Yes ____ No ____ When? ___________________

Double Vision? Yes ____ No ____ When? _________________ Eyes Hurt / Tired? Yes ____ No ____ When? ______________

List any other complaints your child has concerning his/her vision ____

____

VISUAL HISTORY

Date of last visual exam ________________________________ Doctor's Name ___________________________________

Reason for last exam ____

Were glasses prescribed? Yes ____ No ____ Are they worn? Yes ____ No ____ When? ________________________

Family vision conditions: Mother _________ Father _________ Siblings __________

Has your child ever received Vision Therapy? Yes ____ No ____ When? _____________________ Results? _______________

____

GENERAL BEHAVIOR

Are there any behavior problems at school? ____ At home? ____ Please describe _____________________________________

To what do you attribute these problems? ____

____

SCHOOL

Age entering kindergarten? ______ First Grade _____ Does your child like school? Yes ____ No ____ Teacher? Yes ____ No ____ Do you feel that he / she is working up to potential? Yes ____ No ____ Specifically describe any school difficulties

____

Child's academic performance: **Reading** ----- Above Average ____ Average ____ Below Average____
Math--------- Above Average ____ Average ____ Below Average____
Spelling----- Above Average ____ Average ____ Below Average ____
Writing----- Above Average ____ Average ____ Below Average ____

Has grade been repeated? Yes ____ No ____ Which? _________

Does he / she seem to be under tension or extreme pressure when doing school work? Yes ____ No ____ Has he / she had any special tutoring and / or remedial assistance? Yes ____ No ____ When? _____ From whom? _______________ Where? ___________

How Long? __________ Results? ____

____

REASON FOR EVALUATION: OBSERVATIONS

APPEARANCE OF EYES
____ One eye turned In or Out
____ Frequent blinking
____ Squinting or rubbing of the eyes
____ Frequent reddening or tearing of the eyes
____ Encrusted eyelids or frequent sty's

COMPLAINTS WHEN USING EYES FOR DESK WORK
____ Headaches
____ Eyes burning or watering after reading
____ Blur at far or near after or during reading

BEHAVIORAL SIGNS OF POSSIBLE VISUAL PROBLEMS

Eye movement abilities related
____ Loses place often during reading
____ Needs finger or book mark to keep place
____ Head turns as reading across page
____ Too frequently omits words
____ Rereads or skips lines unknowingly
____ Displays short attention span for reading and/or copying

Eye teaming abilities related (eye coordination)
____ Complains of seeing double, words run together
____ Repeats Letters within words
____ Misalign digits in number columns
____ Squints, closes, or covers one eye
____ Tilts head extremely while working
____ Consistently shows gross postural deviations while working at desk
____ Very slow reading speed

Focusing abilities related
____ Fatigues quickly while doing seat work
____ Displays short attention especially for desk work
____ Comprehension reduces as reading continues; Loses interest too quickly
____ Holds book very close; head too close to desk
____ Avoids all possible near-centered task
____ Laborious reading
____ Has good vocabulary but reading comprehension and retention are very low
____ Makes frequent errors in copying from the board or reference books
____ Squints to see the chalkboard, or request to move nearer

Visual perception abilities related
____ Mistakes words with similar beginnings
____ Reverses words, letters, or numbers
____ Confuses Likenesses and minor differences
____ Fails to visualize what is read
____ Whispers to self for reinforcement while reading silently
____ Returns to "drawing with fingers" to decide likes and differences and for counting

OTHER
____ Yearly evaluation
____ No problems, complaints
____ Blur at distance
____ Blur at near
____ Eyes hurt
____ SOI referral

DEVELOPMENTAL HISTORY

Full term pregnancy? __________ Normal birth? __________ Any complications before or after delivery? __________ Did your child crawl? __________ All fours? __________ Was your child active? __________ Now? __________ List any severe illnesses your child has had ______________________________

Habits (thumb sucking, nail biting, etc.) ______________________________

FAMILY AND HEALTH HISTORY

Briefly describe child's physical condition ______________________________

Medication your child is currently using ______________________________

For what condition (s)? ______________________________

Did parents or any of the other children in the family have learning problems? Who? ______________________________ To what extent? ______________________________

Nutrition

Please give a brief description of the nutritional philosophy in the child's home ______________________________

____

Personality

Please give a brief description of your child's personality ______________________________

____

As you complete this form you will recognize the thoroughness with which your child's visual problems will be considered. Your child's future deserves the fullest consideration that you, as a parent, and we, in the office, can provide.

It is often beneficial for us to discuss examination results with your child's school and/or other professionals involved in his / her care. Please sign below to authorize this exchange of information.

Signature ______________________________ Date ______________________________

Parent Name ______________________________ Spouse ______________________________

Home Telephone ______________________________ Work Telephone ______________________________