BURBANK OPTOMETRIC CENTER, INC.

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CHILDREN'S MEDICAL HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Cell Phone: _____ Home Phone: _____

Date of Birth: _____ Gender: _____

Name of School: _____ Grade: _____

PARENT/GUARDIAN INFORMATION

Father/Guardian: _____ Date of Birth: _____

Phone Number: _____ Email Address: _____

Mother/Guardian: _____ Date of Birth: _____

Phone Number: _____ Email Address: _____

Sibling _____ Date of Birth: _____

Sibling _____ Date of Birth: _____

MEDICAL HISTORY

Pediatrician's Name: _____ Date of Last Examination: _____

Results and recommendations: _____

Medications currently using, including vitamins and supplements: _____

For what condition(s)? _____

List illnesses, bad falls, high fevers, etc.: _____

Age	Severe	Mild	Complications

Is your child generally healthy? _____ Yes _____ No

If no, explain: _____

Are there any chronic problems like ear infections, asthma, hay fever, allergies: _____ Yes _____ No

If yes, please list: _____

Has a neurological evaluation been performed? _____ Yes _____ No

By whom? _____ When? _____

Results and Recommendations: _____

Has a psychologist evaluation been performed? _____ Yes _____ No

By whom? _____ When? _____

Results and Recommendations: _____

Has an occupational therapy evaluation been performed? _____ Yes _____ No

By whom? _____ When? _____

Results and Recommendations: _____

Has a speech evaluation been performed? _____ Yes _____ No

By whom? _____ When? _____

Results and Recommendations: _____

Has any other evaluation been performed? _____ Yes _____ No Type? _____

By whom? _____ When? _____

Results and Recommendations: _____

_____

Has your child been diagnosed on the autism spectrum?_____ Yes _____ No

By whom? _____ When? _____

Please list 'stimming' behaviors: _____

Sensory seeking/avoidance behaviors _____

DEVELOPMENTAL HISTORY

Full-term pregnancy: _____ Yes _____ No

Any complications before, during or immediately following delivery? _____ Yes _____ No

If yes, explain: _____

Was there ever any reason for concern over your child's general growth or development? ____ Yes _____ No

If yes, why? _____

Did your child crawl on hands and knees? _____ Yes _____ No At what age: _____

For how long? _____

At what age did your child walk? _____

Speech: First spoke at what age? _____

Is speech clear now? _____ Yes _____ No

Is there any family history of the following? (Please check all that apply)

	Who?		Who?
Strabismus (eye turn)	_____	Learning Disability	_____
Chromosomal Abnormality	_____	Amblyopia (lazy eye)	_____
ADD/ADHD	_____	Dyslexia	_____
Autism Spectrum	_____	Epilepsy or Seizures	_____

VISUAL HISTORY

When was your child's last eye exam by an eye doctor? _____

Name of Doctor: _____ Phone number: _____

Has your child been evaluated by any other eye specialist: _____ Yes _____ No

If yes, Doctor's name: _____ Date of Evaluation: _____

Reason for evaluation: _____

Are glasses or contacts used? _____ Yes _____ No For what activities: _____

If prescribed but not used, why not? _____

PRESENT SITUATION

Why do you feel your child needs a visual evaluation? _____

How long has this problem/difficulty been observed?

_____ Does your child report any of the following?

Comments:

_____ Headache

_____ _____ Blurred vision / vision goes in and out of focus

_____

_____ Double vision _____

_____ Eyes hurt _____

_____ Eyes tired _____

_____ Words move around on the page _____

_____ Dizziness _____

Have you ever noticed the following when your child is reading, writing, or using an electronic device?

_____ Eyes frequently red

_____ Frequent eye rubbing

_____ Frequent blinking

_____ Closing or covering one eye

_____ Difficulty seeing distant objects

_____ Head close to paper when reading or writing

_____ Avoids / dislikes reading

_____ Moves head when reading

_____ Confuses letters or words

_____ Reverses letters or words

_____ Skips, rereads or omits words

_____ Loses place while reading

_____ Reads slowly

_____ Uses finger as a marker

_____ Poor reading comprehension

_____ Writes or prints poorly

_____ Difficulty recognizing same word on different page

_____ Remembers better what is heard than what is seen

_____ Seems to know material, but does poorly on tests

_____ Dislikes / avoids near tasks

_____ Short attention span / loses interest

_____ Poor fine motor coordination

_____ Dislikes / avoids sports

LEISURE TIME ACTIVITIES

How many hours per day does your child spend using any electronic devices? _____ Viewing distance? _____

Hobbies / Sports: _____

SCHOOL

Specifically describe any school difficulties: _____

_____

Has a grade been repeated? _____ Yes _____ No If yes, which grade and why? _____

Has your child had any special tutoring / remedial assistance? _____ Yes _____ No

If yes, when, where and from whom? _____

Results: _____

Does your child have an IEP? _____ Yes _____ No Eligibility? _____

Does your child have a 504 plan?_____ Yes _____ No Eligibility? _____

Which subjects are:

Above average: _____

Average: _____

Below average: _____

Does your child spend more time than necessary of homework? _____ Yes _____ No

To what extent do you assist your child with homework? _____

Do you feel your child is achieving up to potential? _____ Yes _____ No

Please provide any evaluation reports , as well as a copy of the IEP/504 plan.

Give a brief description of your child:

_____

_____

_____

_____

Vision Insurance Plan Name: _____

Identification Number: _____

Insured's Name: _____

Insured's Date of Birth: _____

Patient's relation to insured: _____

Medical Insurance Plan Name: _____

Identification Number: _____

Insured's Name: _____

Group Number: _____

Insured's Date of Birth: _____

Patient's relation to insured: _____

When completed, please upload to your secure online portal emailed to you.