OFFICE USE ONLY
[ ] RTC VIP
[ ] TVPS [ ] GARDNER
[ ] BEERY [ ] WOLD

OFFICE USE ONLY:
RET PHOTO TAKEN [ ]
TAKE RET PHOTO WHEN DILATED [ ]
NO RETINAL PHOTO [ ]
SCANNED [ ]

# EXAMINATION INTAKE FORM – CHILD

PLEASE PRINT CLEARLY

| CHILD'S FULL NAME: | BIRTH DATE (DD/MM/YY): | MALE [ ] FEMALE [ ] |
|---|---|---|
| HOME ADDRESS: | HEALTH CARD #: | |
| CITY: | PARENT'S NAMES: | |
| POSTAL CODE: | CELL PHONE #: | |
| HOME PHONE #: | ALTERNATE #: | |
| EMAIL ADDRESS: | | |
| [ ] **I GIVE** VISUAL SENSE EYE CARE PERMISSION TO EMAIL ME WITH MEDICAL REPORTS, EDUCATION & PERSONAL COMMUNICATIONS<br>[ ]**I DO NOT GIVE** VISUAL SENSE EYE CARE PERMISSION TO EMAIL ME WITH MEDICAL REPORTS, EDUCATION & PERSONAL COMMUNICATIONS | | |
| SIGNATURE OF CONSENT: | DATE OF CONSENT: | |
| HOW WERE YOU REFERRED TO US? | REASON FOR REFERRAL: | |

## HEALTH HISTORY

| FAMILY DOCTOR: | DATE OF LAST EYE EXAM: |
|---|---|
| ALLERGIES (please specify): | HOSPITALIZATIONS: |
| MEDICATIONS: | REASONS FOR MEDICATIONS: |

ANY HISTORY OF: ( IF A FAMILY MEMBER HAS ANY MEDICAL HISTORY, **PLEASE INDICATE WHO [ grandmother, father, etc] )**

| | | | |
|---|---|---|---|
| [ ] **SELF** [ ] **FAMILY** | ENVIRONMENTAL ALLERGIES | [ ] **SELF** [ ] **FAMILY** | HIGH BLOOD PRESSURE |
| [ ] **SELF** [ ] **FAMILY** | HEART DISEASE | [ ] **SELF** [ ] **FAMILY** | CATARACTS |
| [ ] **SELF** [ ] **FAMILY** | ARTHRITIS | [ ] **SELF** [ ] **FAMILY** | GLAUCOMA |
| [ ] **SELF** [ ] **FAMILY** | HIGH CHOLESTEROL | [ ] **SELF** [ ] **FAMILY** | STROKE |
| [ ] **SELF** [ ] **FAMILY** | MACULAR DEGENERATION | [ ] **SELF** [ ] **FAMILY** | RETINAL DETACHMENT |
| [ ] **SELF** [ ] **FAMILY** | EYE INJURY | [ ] **SELF** [ ] **FAMILY** | TUBERCULOSIS |
| [ ] **SELF** [ ] **FAMILY** | DIABETES | [ ] **SELF** [ ] **FAMILY** | HIV/ HEPATITIS |
| [ ] **SELF** [ ] **FAMILY** | EYE SURGERY | [ ] **SELF** [ ] **FAMILY** | NEUROMUSCULAR |

## VISUAL HISTORY & EYE HEALTH

| | |
|---|---|
| [ ] BLURRED DISTANCE VISION / SQUINTING | [ ] UNCOMFORTABLE CONTACT LENSES |
| [ ] BLURRED INTERMEDIATE VISION | [ ] AMBLYOPIA (LAZY EYE) |
| [ ] BLURRED CLOSE VISION | [ ] DROOPING EYELID |
| [ ] SUDDEN VISION LOSS | [ ] FLUCTUATING VISION |
| [ ] DOUBLE VISION | [ ] GLARE/ LIGHT SENSITIVITY |
| [ ] FLOATING SPOTS | [ ] MUCUS DISCHARGE |
| [ ] RED EYES | [ ] STRABISMUS |
| [ ] WATERY EYES/ BURNING EYES | [ ] CORNEAL TRANSPLANT |
| [ ] FREQUENT HEADACHES | [ ] EYE TURN |
| [ ] FLASHES OF LIGHT | [ ] KERATOCONUS |
| [ ] DRY EYES | [ ] OTHER: |

| HISTORY OF CONCUSSION: **[ ] YES [ ] NO** | DATE OF LAST CONCUSSION (MM/DD/YY): |
|---|---|
| PARTICIPANT OF COMPETITIVE SPORT : **[ ] YES [ ] NO** | **SEE BACK ->** |

## VISUAL HISTORY

Any learning-related diagnosis? **[ ] YES [ ] NO** IF SO, PLEASE LIST:

Please describe any previous eye or visual problems and treatment your child has received (including glasses, vision therapy, patching, surgery, medications, etc…):

## EDUCATIONAL HISTORY

CURRENT SCHOOL: GRADE:

HAS YOUR CHILD REPEATED ANY GRADES? **[ ] YES [ ] NO** IF YES, WHICH ONES?

IS YOUR CHILD RECEIVING ANY TUTORING, EXTRA HELP OR SPECIAL CLASSES? **[ ] YES [ ] NO** IF YES, PLEASE DESCRIBE:

## ACADEMIC COMPLAINTS

- [ ] LOSS OF PLACE WHILE READING/ SKIPPING WORDS & LINES
- [ ] POOR HANDWRITING
- [ ] HOLDS BOOK TOO CLOSE
- [ ] POOR SPELLING
- [ ] POOR, INEFFICIENT READING
- [ ] MATH DIFFICULTY: FACTS/ CONCEPTS
- [ ] WORDS MOVING OR RUNNING TOGETHER
- [ ] DIFFICULTY COPYING FROM THE BOARD
- [ ] POOR READING COMPREHENSION
- [ ] AVOIDS READING
- [ ] FREQUENT LETTER, NUMBER OR WORD REVERSALS

## CURRENT ACADEMIC LEVELS ( PLEASE CHECK APPROPRIATE BOX)

| | ABOVE GRADE | ON GRADE | BELOW GRADE | SPECIAL HELP |
|---|---|---|---|---|
| READING | | | | |
| READING COMPREHENSION | | | | |
| SPELLING | | | | |
| MATH | | | | |
| HANDWRITING | | | | |

## DEVELOPMENTAL HISTORY

WERE THERE ANY COMPLICATIONS WITH PREGNANCY OR DURING BIRTH? **[ ] YES [ ] NO** IF YES, PLEASE DESCRIBE:

WAS YOUR CHILD BORN PREMATURELY? **[ ] YES [ ] NO** IF YES, HOW SOON?

CHILD'S BIRTH WEIGHT: APGAR SCORE:

WHEN DID YOUR CHILD BEGIN WALKING UNASSISTED?

WHEN DID YOUR CHILD BEGIN TO CRAWL?

WHEN DID YOUR CHILD BEGIN TO SPEAK 2-3 WORD PHRASES?

IS YOUR CHILD CLUMSY? **[ ] YES [ ] NO**

ANY SPEECH PROBLEMS NOW OR IN THE PAST? **[ ] YES [ ] NO**

ANY PROBLEMS WITH FINE MOTOR CO-ORDINATION? **[ ] YES [ ] NO**

DOES YOUR CHILD ENJOY, AND PARTICIPATE IN ACTIVITIES SUCH AS DRAWING, COLOURING, PUZZLES, BLOCK PLAY, ETC?
**[ ] YES [ ] NO** (WITH OLDER CHILDREN, DID THEY PREVIOUSLY?) **[ ] YES [ ] NO**

OTHER NECESSARY INFORMATION, PLEASE INDICATE: