Dr. Wynn N. Tran
Integrative Optometry & Vision Rehab/Therapy

DATE:___/___/____

PEDIATRIC PATIENT HISTORY QUESTIONNAIRE

PATIENT INFORMATION:

PATIENT LAST NAME ____________________________ FIRST NAME:____________________________ MI:____
BIRTHDATE ___/___/___ AGE______ GENDER: ________ GRADE: _______ SCHOOL:_______________________
EMAIL:_______________________________________ CELL PHONE: ( )________________________________
HOME PHONE: ( ) ___________________________OTHER PHONE: ( )________________________________
ADDRESS: ____________________________________ CITY:___________________________ ZIP:______________
OCCUPATION:_____________________________ EMPLOYER or SCHOOL:_________________________________
HOBBIES (SPORTS): ____
EMERGENCY CONTACT _________________________________PH:( )__________________________________
WHO REFERRED YOU (YOUR CHILD)?____

FAMILY & HOME INFORMATION:

PARENT/GUARDIAN NAME:_________________________________RELATIONSHIP:_______________________
CONTACT INFO: ___________________________________OCCUPATION: _________________________________
PARENT/GUARDIAN NAME:_________________________________RELATIONSHIP:_______________________
CONTACT INFO: ___________________________________OCCUPATION: _________________________________

WHAT ARE THE REASONS FOR TODAY'S VISIT (check all that apply)?

- ❑ Annual eye exam
- ❑ Distance blur
- ❑ Near/Reading blur
- ❑ Double vision
- ❑ Problems with Computer use
- ❑ Brain Injury or Neurological problem ____
- ❑ Lost or broken glasses
- ❑ Not effective glasses
- ❑ Never worn glasses
- ❑ Learning difficulties
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Unusually sensitive to light
- ❑ Eye pain/discomfort
- ❑ Other: ____________________________

Reason for today's visit/Goals:

____
____
____
____

MEDICAL & EYE HISTORY

DO YOU OR ANY RELATIVES (parents, siblings, children, grandparents, aunt, uncle) HAVE ANY OF THE FOLLOWING? (check and indicate who has the condition)

Condition	Self:	Other:
❑ Diabetes	❑	❑______________
❑ High Blood Pressure	❑	❑______________
❑ Arthritis	❑	❑______________
❑ Thyroid problems	❑	❑______________
❑ Lung Disease	❑	❑______________
❑ Heart Disease	❑	❑______________
❑ Gastrointestinal	❑	❑______________
❑ Ears/nose/throat	❑	❑______________
❑ Immune	❑	❑______________
❑ Headaches/Migraines	❑	❑______________
❑ Other:	❑	❑______________
❑ Eye Disease or Injury	❑	❑______________
❑ Eye Surgery	❑	❑______________
❑ Glaucoma	❑	❑______________
❑ Cataracts	❑	❑______________
❑ Macular Degeneration	❑	❑______________
❑ Retinal Degeneration	❑	❑______________
❑ Crossed/Lazy Eye	❑	❑______________
❑ Excessive blinking	❑	❑______________
❑ Mental	❑	❑______________

List any MEDICATIONS you are now taking: ____
____

List any ALLERGIES you have: ____
Have you had any operations: ❑ Y ❑ N When? What kind? ____________________________________

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Name of FAMILY DOCTOR? ________________________________ Date of last visit: __________________________
Name of OTHER PROVIDERS/THERAPISTS involved in care: ____

____

____

Date of last eye exam: ________ Have you had your eyes dilated before? ❑ no ❑ yes when?___________________
Age of present glasses ________yrs
If contact lens wearer, age of CL's________yrs Type: ❑ Soft ❑ RGP/Hard ❑ Color ❑ Monovision ❑ Bifocal
Method of Wear: ❑ Daily wear ❑ Overnight wear Replacement schedule: ❑ 2 weeks ❑ 1 month ❑ Other:_________

DEVELOPMENTAL HISTORY

	No	Yes	If yes, please explain:
Any severe childhood illness, high fever, injury, or physical impairment?			
Any diagnosed hearing impairment?			
Any neuropsych or other evaluations?			Date, type of evaluation:
History of previous (or current) therapy for learning, visual, occupational, physical, and/ or speech difficulties?			Date, duration, type of therapy, result:
Any head injuries/concussions?			Date, describe:

Pregnancy & Birth History

	No	Yes	Comments
Normal pregnancy?			
Normal birth history?			
Normal gestation time			If premature, number of weeks? =
Normal birth weight			Lbs: ______ Oz:_______
Normal Apgar score			Score: _____________

Developmental Milestones

	No	Yes	If no, when?
Turned head to locate sound by 6mo			
Followed simple instructions by 2yrs			
Said first word at 12 months			
Used sentences of more than three words by 4 yrs			
Reached for objects by 7 months			
Searched for objects that are hidden while watching by 12 months (Ex: Peek-a-boo)			
Copied a circle by 4 yrs			
Grasped a crayon between thumb & finger by 4 yrs			
Walked unaided by 18 months			
Jumped in place by 4 yrs			

Comments about development (ie: learning issues, developmental delay).
Please provide our office a copy of prior evaluations.

____

____

____

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Behavior

	Never	Rarely	Occasionally	Frequently	Always
Hyperactive					
Easily distracted					
Short attention span					
Easily frustrated					
Impulsive					
Easily fatigued					
Poor ability to organize work					
Indistinct speech					
Awkward or clumsy					
Behavior problems					
Emotional problems					
Confusion following a series of verbal instructions					
Variable school performance (from hour to hour/ day to day)					
Reverses letters, words, or numbers in reading					
Reverses letters, words, or numbers in writing					
Shows confusion about right/left or directional orientation					

ACADEMIC INFORMATION

Resources/Accommodations	**No**	**Yes**	**If yes, when and for what recommendations?**
504 Plan			
IEP (Individualized Education Program)			
Evaluated for Learning Issues?			

Rate child's progress in following subjects.

Subject	**Above grade level**	**At grade level**	**Below grade level**	**What specific areas or academic skills is your child experiencing difficulty? Comments:**	**Any family member with learning difficulties? Please indicate subject and relationship to child.**
Reading					
Spelling					
Writing					
Arithmetic					
Art					
Music					
Phys. Education					
Other? Please list:					

Additional Comments:

____
____
____
____
____

Parent/Guardian Name: ______________________ Relationship to child: ____________________
Signature: ______________________ Date: __________
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Signature: ______________________ Date: __________