**Delta Vista Optometry**
**Pediatric History**

Date:__/__/__

Patient Name:________________________
Address:______________________________
_____________________________________
DOS:_____________ DOB:_____________
Insurance:____________________________
Last Medical Exam:__/__/__

Pediatric/Medical Doctor information
Name:______________________________
Address:______________________________
______________________Zip:___________
Phone:_________________________________
Who filled out this form? Name:_________
Relation to Child:______________________

My child is here today because: ____________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Have there been any severe childhood illnesses, injuries, or physical impairment?
Yes_ No_ If yes, please describe:______________________________________________________
_________________________________________________________________________________

Any current health problems? Yes_ No_If yes, please describe:__________________________
_________________________________________________________________________________

Is your child taking any medications? Yes_ No_ If yes, please list:_________________________

Any Allergies? Yes_ No_ If yes, please describe:_________________________________________

Educational History
Has your child repeated any grade? Yes_ No_ If yes, which one?_________________________
Is your child receiving any extra help in school or in any special classes? Yes_ No_
Have there been any evaluations done at school or by school recommendations? Yes_ No_ If yes please circle: (psychological, educational, speech/language, occupational therapy, neurological, medical)

Has your child been diagnosed with any of these problems listed below?
__Learning or reading problem
__Dyslexia
__Autism, Asperger's, Pervasive Development Disorder
__Nonverbal learning disability
__ Attention Deflect Hyperactivity Disorder
__Other:_______________________

Please check any of the following that you or teacher has noticed or your child complains about:
__ Frequent headaches
__Blurry vision when reading
__Reverses letters/numbers/words
__Homework takes longer than should
__Eye turning in or drifting out
__Double vision
__Trouble copying the board
__Poor reading comprehension
__Trouble concentrating when reading
__Loss of place when reading
__Reads slowly
__Avoids reading
__Uses fingers to keep when reading