The information in this confidential personal history form is critical to the evaluation of your child's vision

Foday's Date		_				
Name	Age	Birthdate				
Date of child's last eye examination	Has child	Has child ever had vision therapy? ☐ Yes ☐				
Has Child ever worn glasses? If yes: ☐ for distance only				☐ Yes ☐ No		
Does child wear contact lenses?	□ Yes □No	Any problems	s?	· · · · · · · · · · · · · · · · · · ·		
			_			
This is your opportunity	to tell us abo	ut all areas of	f concern about your	child's vision.		
What is your main reason	for coming h	ere today?				
Have you noticed any unu	ısual signs or	symptoms th	nat concern you?			
Has your child's ability to	do any activit	ty been restri	cted because of vision	n?		
Please explain						

HEALTH HISTORY: Check any conditions that apply to your child or that run in your family.

Recording				Lazy eye		بأراد المسالم
Respiratory		□ Family		Turned eye	☐ Child	☐ Family
disease Cancer	☐ Child☐ Child☐	☐ Family☐ Family		Color "blind" Light sensitive	☐ Child☐	☐ Family ☐ Family
Diabetes	☐ Child	☐ Family		Eyestrain	☐ Child	☐ Family
Drug sensitive		☐ Family		Dry eyes	☐ Child	☐ Family
Heart problem		☐ Family		Floaters/spots	☐ Child	☐ Family
High blood	- Crilia	a ranniy		Flashing lights	☐ Child	☐ Family
pressure	☐ Child	□ Family		Retinal	- Orma	T anning
Thyroid	☐ Child	☐ Family		detachment	☐ Child	□ Family
Migraine or	□ Offilia	a ranniy		Cataracts	☐ Child	☐ Family
headaches	☐ Child	□ Family		Glaucoma	☐ Child	☐ Family
Blindness	☐ Child	☐ Family		Eye surgery	_ 0	<u> </u>
Head trauma	☐ Child	_:,		or injury		
Is your child curre	ntlv under a p	hysician's care?	□ Yes	□ No Whv?		
		s or medications?		☐ No Specify		
•						
Date of child's last	: physical	How	v is child's	general health?		
		.	(5 4			
Full Term Pregnar	ıcy? □ Yes	Developmer ☐ No	ntal Milest Normal B		Yes □ No	
Any complications	before, durin	g or immediately fo	ollowina d	eliverv?	Yes □ No	
Please describe		g				
		ich on floor)? ☐ Yes	e DNo	at what age?		
·	• '	· ·		-		
Did your child	crawl (stoma	ch off floor)? 🖵 Yes	s 🖵 No	at what age?_		
•						
•	move around	l on all fours? 🗆 Ye	s 🖵 No	at what age?_		
Did your child				-		
Did your child At what age d	id your child v	valk? V	Vas your	child active? 👊	Yes □ No	s 🗆 No
Did your child At what age d Speech:		valk? V age V	Vas your	child active? 🔲	Yes □ No	s □ No
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	Short attention span? Can concentr Daydreams a lot? Stares off into the Learns best through auditory tactics Misbehavior has become a problem Acts up when asked to do schart Class clown, "goofs off" Moody or depressed about so Aggressive, hits or dominates Avoids work that includes reading or Is more than 1 year behind group in Has poor posture? Slouches, slump	e distance (listens t (to cover nool work chool and other ch near see reading-	e freque o learn) r up poo d d life nildren eing? related s	ently? ? or school performance)?
	N AND LEISURE: In what recreation all, basketball, soccer, swims, build mo			
Other recre	eational or sports activities?			
Does your Does your Does your Does child	child wear protective eyewear for his/ child watch much television? child use a computer at home? child use a computer at school? I often play video games? he play hand-held video games?	☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes	□ No □ No □ No □ No	Number of hours dailyNumber of hours dailyNumber of hours dailyNumber of hours daily
amount, or your in	nsurance pays you directly, we ask that you pay ntact lenses are to be ordered, a minimum 50 sonal checks, Visa and Mastercard. A monthl	y the balan % deposit y rebilling	ce. Office is reques fee of \$5	n. If your insurance will not pay the anticipated e policy calls for payment at the time of service. Ited and the balance is due upon delivery. We is added to all accounts with unpaid balances
Lhava	I have read and agree to all the p received/reviewed a copy of the health care info			
rnave	received/reviewed a copy of the health care into	οιπαιίση ρι	ivacy poli	cy for simpson and mann optomeny
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