Advanced Eyecare Specialists
www.aeswpb.com

General Information

Child's full name_____
Age_____ Birth date _____
School_____
School Address_____
_____
Grade _____Teacher_____
Principal_____
Is your child especially afraid of doctors? ☐Yes ☐ No

Parent Information

Father's Full Name_____
Home Address ☐ Same as patient address on Welcome Form
Address_____
City _____State _____Zip_____
Phone: H_____ C_____
E-mail_____
Father's occupation_____
Employer_____
Work Phone_____

Mother's Full Name_____
Home Address ☐ Same as patient address on Welcome Form
Address_____
City _____State _____Zip_____
Phone: H_____ C_____
E-mail_____
Mother's occupation_____
Employer_____
Work Phone_____

Medical History

Most recent medical examination:
Doctor's name_____
Date_____
Results_____
_____
Medications currently using? _____
For what condition? _____
Drug allergies_____

School Age Child History

Please bring this form to your child's appointment or return by email before the appointment. If your child has had an Individualized Education Program (IEP), or other testing which Dr. Manes should be aware of, please provide a copy.

Has your child been diagnosed as having:

☐ Learning disabilities ☐ Developmental delays
☐ ADD or ADHD ☐ Cerebral Palsy
☐ Seizure disorders ☐ Autism
☐ Brain injury ☐ Dyslexia
☐ Auditory Processing Delay
☐ Other_____

List illnesses, bad falls, head injuries, ear infections, high fever etc. (include complications and ages)

_____
_____
_____

Is your child generally healthy?_____
Are there any chronic problems like asthma, hay fever, allergies?_____
If so, please list_____
_____
Has a neurological evaluation been performed? ☐ Yes ☐ No
By whom?_____
Results_____
_____
_____
Has a psychological evaluation been performed? ☐ Yes ☐ No
By whom?_____
Results_____
_____

Does your child currently receive:

Occupational therapy services? ☐ Yes ☐ No
By whom?_____
Results_____
_____
Physical therapy services? ☐ Yes ☐ No
By whom?_____
Results_____
_____
Speech therapy services? ☐ Yes ☐ No
By whom?_____
Results_____
_____
Auditory Training? ☐ Yes ☐ No
Other therapy services? ☐ Yes ☐ No
Describe_____
_____

Nutritional Information

Current Diet: □ Excellent □ Good □ Fair □ Poor
Does your child crave sweets?_____
Is your child □ Moderately active □ Extremely active
Are there periods of high energy? □ Yes □ No
Low energy? □ Yes □ No

Developmental History

Full term pregnancy? □ Yes □ No Normal Birth? □ Yes □ No
Birth weight?_____ Was birth ___ induced ___ c section?
Any complications before, during, after or immediately following delivery?_____
Did your child crawl (stomach **on** floor)? □ Yes □ No
Age_____
Did your child creep (stomach **off** floor)? □ Yes □ No
Age_____
Did your child move on all fours? □ Yes □ No
Age_____
If not describe_____
_____
At what age did your child walk?_____
Was child active? □ Yes □ No
Speech: First words at age_____
Was early speech clear to others? □ Yes □ No
Is it clear now? □ Yes □ No
Any history of crossing eyes? □Yes □No
What age first noticed_____
Any **family** history of crossing eyes? □Yes □No
Who?_____

Visual History

Previous eye examination: Doctor's name_____
_____
Date_____
Reason for examination_____
Results_____
_____
Were glasses prescribed? □ Yes □ No
Are they worn? □ Yes □ No □ Full-time □ Part-time
Comments_____
Are eye exams done yearly? □ Yes □ No
Members of the family who have had visual attention and why:

Name	**Age**	**Visual Situation**

Present Situation

Is there any concern from any other professional that some visual dysfunction may be present? □ Yes □ No
Describe_____
_____
_____
_____
Does your child report any of the following:
Headaches □ Yes □ No
When?_____
Blurred vision □ Yes □ No
When?_____
Double vision □ Yes □ No
When?_____
Eyes "hurt or tired" □ Yes □ No
When?_____
List any other complaints that your child makes concerning his/her vision_____
_____
_____
_____
_____
_____
_____

Have you ever noticed the following:

Eyes frequently reddened □ Yes □ No
If so, when?_____
Frequent eye rubbing □ Yes □ No
If so, when?_____
Frequent blinking □ Yes □ No
If so, when?_____
Closing or covering one eye □ Yes □ No
If so, when?_____

Head close to paper when reading or writing	□ Yes	□ No	□ N/A
Tilting head when reading	□ Yes	□ No	□ N/A
Tilting head when writing	□ Yes	□ No	□ N/A
Confuses letters or words	□ Yes	□ No	□ N/A
Reverses letters or words	□ Yes	□ No	□ N/A
Skips, rereads or omits words	□ Yes	□ No	□ N/A
Vocalizes when reading silently	□ Yes	□ No	□ N/A
Reads slowly	□ Yes	□ No	□ N/A
Uses finger as a marker	□ Yes	□ No	□ N/A
Poor reading comprehension	□ Yes	□ No	□ N/A

Writes or prints poorly ☐ Yes ☐ No ☐ N/A
Tires easily ☐ Yes ☐ No ☐ N/A
Avoids near tasks ☐ Yes ☐ No ☐ N/A
Short attention span ☐ Yes ☐ No ☐ N/A
Poor motor coordination ☐ Yes ☐ No ☐ N/A
Difficulty catching/hitting a ball ☐ Yes ☐ No ☐ N/A
Television viewing: How much_____
How often_____Viewing distance_____
Average amount of sleep per night_____

School

Age at entrance to kindergarten_____
Does child like school? ☐ Yes ☐ No
Teacher? ☐ Yes ☐ No
School work is: ☐ Above Average ☐ Average ☐ Below Average

Do you feel he/she is working up to potential?
_____
Does teacher feel he/she is working up to potential?
_____
What school subjects come easy for child?
_____
_____
_____

Does child like to read? ☐ Yes ☐ No
Voluntarily? ☐ Yes ☐ No
What?_____
_____
Specifically describe any school difficulties:
_____
_____
_____
_____

Has a grade been repeated? ☐ Yes ☐ No
Which?_____
Has he/she changed schools often?_____
When?_____

Does he/she seem to be under tension or extreme pressure when doing schoolwork?_____

Has he/she had any special tutoring and/or remedial assistance? ☐ Yes ☐ No
When?_____
From whom?_____
Where?_____
How long?_____
Results_____
_____
How well developed is his/her spoken vocabulary?
_____
What is the child's attitude toward reading, school, his/her teacher, other youngsters?_____
_____
_____

General Behavior

Are there any behavior problems? ☐ Yes ☐ No
School_____Home_____
What causes these problems?
_____
_____

Child's reaction to fatigue: ☐ None ☐ Sad ☐ Irritable ☐ Other_____
Child's reaction to tension? ☐ None ☐ Nail biting ☐Thumb sucking ☐Other_____

Does he/she say and/or do things impulsively? ☐ Yes ☐ No
Is your child in constant motion? ☐ Yes ☐ No
Can your child sit still for long periods? ☐ Yes ☐ No

Family and Home

Please indicate which adults he/she lives with:
☐ Mother ☐ Father ☐ Step Mother ☐Step Father
☐ Foster Parents ☐ Adopted Parents ☐ Grandmother
☐ Grandfather ☐ Aunt ☐ Uncle
☐ Other_____

Siblings: Names Ages
_____
_____
_____
_____

If applicable, please describe your child's custody agreement:
_____
_____
_____
_____

Has he/she ever been through a traumatic family situation? (Such as divorce, parental loss, separation) ☐ Yes ☐ No
What age was he/she?_____
Does he/she seem to have adjusted?_____

Is family life stable at this time? ☐ Yes ☐ No

How does he/she get along with parents?_____

_____

Siblings?_____

Classmates at school?_____

Playmates at home?_____

Did anyone in father's family have a learning problem?

☐ Yes ☐ No

Who?_____

_____

Did mother or anyone in mother's family have a learning problem? ☐ Yes ☐ No

Who?_____

_____

Do any, or did any of the other children in the family have learning problems? ☐ Yes ☐ No

Who?_____

To what extent?_____

_____

_____

Give a brief description of your child as a person:_____

_____

_____

_____

_____

_____

_____

Additional comments/concerns that you would like Dr. Andrich to be aware of:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Report Policies

Would you like copies of any reports? ☐ Yes ☐ No

Would you like copies sent anywhere? ☐ Yes ☐ No

Name_____

_____

Address_____

_____

_____

Name_____

_____

Address_____

_____

_____

Name_____

_____

Address_____

_____

_____

(For any others please use the back of this form)

Please sign below to give us permission to release information about your child to the above sources.

Signed_____

Date_____