KRISTIDAVISOD
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2013: _________
2014: _________
2015: _________

DEVELOPMENTAL HISTORY FOR MINOR

Name of Minor: ________________________________ Date of Birth: __________________ Date: ____________

PRESENT SITUATION

Why do you feel your child needs a visual examination?
❑ Yearly examination ❑ Blur at distance ❑ Blur at near ❑ Eyes hurt ❑ Referral ❑ Other ____________

Is there any evidence from the school or psychological tests that some visual difficulties may be present? ❑ yes ❑ no
If yes, please describe ____

VISUAL HISTORY

Date of last visual examination ______________ Doctor's Name ______________________________
Reason for last exam ____
Family vision conditions Mother ______________ Father ______________ Siblings ________________
Has your child ever received vision therapy? ❑ yes ❑ no If yes, when? ___________________________
Results? ____

Does minor wear glasses? ❑ no ❑ yes If yes, how old is their present pair of glasses?_______________
Does minor wear sunglasses? ❑ no ❑ yes If yes, how old is their present pair of sun glasses? _______________
Does minor wear contact lenses? ❑ no ❑ yes If yes, how old is their present pair of contacts? _____________
Type of contact lenses: ❑ Disposable ❑ Soft ❑ Gas Permeable ❑ Other Are they comfortable? ❑ no ❑ yes
When does minor wear their present glasses? All of the time _____ Distances Only _____ Near Only _____

GENERAL BEHAVIOR

Are there any behavior problems at school? _____ At home? ______ Please describe _______________________
To what do you attribute these problems? ____

SCHOOL

Age entering kindergarten? _____ First grade?______ Does your child like his/her teacher? ❑ yes ❑ no
Does your child like school? ❑ yes ❑ no Do you feel that your child is working up to his/her potential? ❑ yes ❑ no
Specifically describe any school difficulties ____

Child's academic performance:

Reading	❑ Above average	❑ Average	❑ Below Average
Math	❑ Above average	❑ Average	❑ Below Average
Spelling	❑ Above average	❑ Average	❑ Below Average
Writing	❑ Above average	❑ Average	❑ Below Average

Has a grade been repeated? ❑ yes ❑ no Which grade? _______________
Does he/she seem to be under tension or extreme pressure when doing schoolwork? ❑ yes ❑ no

Has he/she had any special tutoring and/or remedial assistance? ❑ yes ❑ no When? ____________________
From whom? ________________________________ How long? ___________ Results? ____________________

PLEASE TURN OVER AND COMPLETE OTHER SIDE

OBSERVATIONS (Check all that apply)

- ❑ One eye turned in or out
- ❑ Frequent blinking
- ❑ Rubbing of the eyes
- ❑ Frequent reddening or tearing of the eyes
- ❑ Encrusted eyelids or frequent styes
- ❑ Headaches
- ❑ Eyes burning or watering after reading
- ❑ Blur at far or near after or during reading
- ❑ Loses place often during reading
- ❑ Needs finger or bookmark to keep place
- ❑ Head turns when reading across page
- ❑ Too frequently omits words
- ❑ Rereads or skips lines unknowingly
- ❑ Displays short attention span for reading or copying
- ❑ Complains of seeing double, words run together
- ❑ Repeats letters within words
- ❑ Misaligns digits in number columns
- ❑ Squints, closes, or covers one eye
- ❑ Tilts head extremely while working
- ❑ Consistently shows gross postural deviations while working at desk
- ❑ Very slow reading speed
- ❑ Fatigues quickly while doing near work
- ❑ Comprehension reduces as reading continues
- ❑ Holds book very close; head too close to desk
- ❑ Avoids all possible near-centered tasks
- ❑ Laborious reading
- ❑ Has good vocabulary but reading comprehension and retention are very low
- ❑ Makes frequent errors in copying
- ❑ Squints to see the chalkboard or moves closer
- ❑ Mistakes words with similar beginnings
- ❑ Reverses words, letters, or numbers
- ❑ Confuses likenesses and minor differences
- ❑ Fails to visualize what is read
- ❑ Whispers to self for reinforcement while reading
- ❑ Returns to "drawing with fingers" to decide likes and differences and for counting

PRENATAL, PERINATAL, POSTNATAL AND DEVELOPMENTAL HISTORY

Full term pregnancy? ____ Normal birth? ______ Any complications before or after delivery? ____________________________

____

____

Did your child crawl? ______ All fours? _______ Was your child active? ______ Is your child active now? __________

Habits? (Thumb sucking, nail biting, etc.) ____

FAMILY AND HEALTH HISTORY

Briefly describe your child's physical condition ____

Did parents or any other children in the family have learning problems? ❑ yes ❑ no If yes, who? ____________________

To what extent? ____

REPORT

Would you like us to send a report to your child's school, medical doctor, etc? ❑ yes ❑ no

If yes, to whom? ____________________________________ Address ____

Phone ____ City ___________________________________ Zip __________

______________________________________ Parent Print Name

______________________________________ Parent Signature

______________________________________ Spouse Print Name

______________________________________ Home Phone Work Phone