

Child's name _____

Parents/Guardian _____

Address _____

Phone _____

Present Situation

1. What is the reason for the visual consultation?

2. Do you observe any of the following:

- Unusual redness of eye
- Unusual redness of lids
- Crusted lids
- Styes or sores on lids
- Excessive watering
- Unusual lid droopiness
- One eye turning IN or OUT with fatigue
- Excessive rubbing of eyes
- Frequent closing of one or both eyes
- Unusual clumsiness and bumping into objects

3. If your child exhibits an "Eye Turn": _____

At what age was the eye turn first noticed? Which eye turns?

Is the turn always present or only occasionally?

Could it be caused by any injury or illness?

Does it turn "IN" or "OUT"

Is it always the same eye? _____

Please bring to the examination any photos that shows the turn

Visual History

Previous visual examination date" _____ / _____ / _____

Reason for examination _____

Results _____

Previous Treatments

- Optical (glasses) Occlusion (eye patching)
- Vision training Surgical
- Medication (e.g. eye drops or ointment)

Please describe

Family History

Is there any family history of "Eye Turn", "Lazy Eye"

or refractive problem? _____

Other children in the family who have had visual attention and why?

Present Health

How would you rate your child's present general health?

- Good Fair Poor

Are any medications currently being taken?

Please detail important aspects of past health history:
(Accidents, head/eye injuries, serious infections, high fevers,
major surgeries, etc.)

Development History

Was pregnancy and birth free from complications?

Have the following development areas been progressing as you would expect?

	Good	Fair	Poor
General growth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Talking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hearing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Social behaviour	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
General coordination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please bring to the examination any glasses that are presently worn by your child, or have been worn in the past. Please bring additional information, reports from other professionals, etc., which you consider important to our understanding of you child.

Do you need a detailed written report on the evaluation of you child's eyesight and visual performance capabilities and optometric recommendations. Yes No

Please list the names and addresses of people to whom you would like a copy of the report sent.
