SIGHT FOR LIFE
OPTICAL BOUTIQUE
DR ROBERTSON-WOODS & ASSOCIATES

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Dr. Robertson-Woods & Assoc. - Child/Student Medical History Form

Please fill out the child's/ student's information below to the best of your ability.

Personal Information

First Name:	Middle Initial:	Last Name:	
Preferred Name:	DOB:	Age:	Grade:
Attending which school?	Height:	Weight:	
Address:		Apt #:	
City:	State:	Zip:	
Phone:	E-mail:		
Mother's Name:	Mother's Cell:		
Father's Name:	Father's Cell:		
Date of last vision exam:	Primary Care Physician:		
Who may we thank for referring you to us?			

Vision Insurance

Vision insurance covers a routine eye exam, which is the preventative, yearly vision exam that helps maintain good eye health.

Insurance Company:	Policy #:	Group #:
Primary Insured:	Primary Insured DOB:	

Medical Insurance

Health or medical insurance covers eye exams and treatment plans only when they are necessary to treat a medical eye condition.

Insurance Company:	Policy #:	Group #:
Primary Insured:	Primary Insured DOB:	

Medical History

What would you like to address with the doctor today?

At which distance is the child/ student having difficulties (circle all that apply): Near Far Computer

Reason for visit (circle all that apply): First Exam Routine Exam Change or Update Prescription

Occupational/ Physical Therapy Referral Doctor Recommendation
School Recommendation Educational Referral
Underachieving in School Underachieving in Sports
Developmental Delays Traumatic Head Injury
Other:

Does the child/ student have trouble with visual acuity (blur)? Blurred vision at a distance Blurred vision at near

Visual Symptoms: (circle all that apply)	squinting eye strain sitting close to a TV games) car/ motion sickness double vision	words run together print coming in and out of focus trouble with 3D media (TV, movies, ocular fatigue with near work sensitivity to light
Eye Health Symptoms: (circle all that apply)	sensitivity to light redness itching watery eyes blinking frequent styes	double vision blurring eyelids crusty rubs eyes eye turns in and wanders out

Undiagnosed and untreated vision problems are holding back millions of students just when learning and healthy development are the most important!

There are a number of symptoms other than blur that can indicate a vision problem that can interfere with learning. We care about students' academic success and want to make sure that they are performing at their full potential this school year.

Classroom / Developmental Performance (circle all that apply):	Performance below expectations Loss of place while reading Inconsistencies numbers/letters Skips lines/words Covers one eye while reading Excessive head movement while reading Little or no voluntary reading Hyperactivity Trouble copying Poor posture Bumps into objects Difficulty spelling Confuses right and left Unusual pencil grip Falls asleep reading Diagnosed with Dyslexia	Reads below grade level Misreads words Follows with finger to keep in place Holds reading material too close or far away Letter reversals Turns or tilts head while reading Long time to finish assignments Poor concentration Poor handwriting Poor coordination Poor reading comprehension Difficulty with math Avoids team sports Avoidance of near work Doesn't recognized same word in next sentence Diagnosed with ADD/ ADHD

Have you ever had a head injury, concussion, or whiplash?

Does the child/ student currently wear:	Glasses?	How often? Circle all that apply: full-time near only distance only computer	
	Contacts?	What type?	
Contact Wearers:	Daily wear time?	Wear time today?	Contact Solution Used?

Does the child/ student currently have any of the following health problems in the following areas?

Allergy: Medications Pollen Dust Shellfish Animal Dander Molds Other:

Cardiovascular: Heart Disease Hypertension Elevated Cholesterol

Constitutional: Dizziness Weight loss/gain Cold Cough Fever

Endocrine: Diabetes Thyroid Disease

Gastrointestinal: Acid Reflux Ulcer Colitis Gall Stones

Genitourinary: Bladder Infection Kidney Stones

Head/ENT/Dental: Dry Mouth Ear Infection Headaches Sinusitis

Hematological/Lymphatic: Sickle Cell Leukemia Lymphatic Cancer Anemia

Immunologic: AIDS Herpes Simplex Herpes Zoster Mononucleosis

Integumentary (skin): Acne Rosacea Psoriasis Lupus Skin Lesions

Musculoskeletal: Arthritis Myasthenia Gravis Osteoporosis

Neurological: Bell's Palsy Multiple Sclerosis Migraine Headaches Epilepsy
Psychiatric: Alzheimer's Autism Anxiety Depression Attention Disorder
Respiratory: Asthma Bronchitis COPD Pneumonia Lung Disease Cancer
Cancer (type and date):
Please list any and all medications, vitamins, herbal supplements and eye drops that the child/ student is currently taking (if you do not know that name, please list the condition for which the child/student is taking the medication):
List any eye surgeries and the dates:
Social History (circle all that apply): Tobacco Alcohol None

Family Medical History

Do any of your close blood relatives have any of the following (please indicate which family member)?
Cataracts:
Macular Degeneration:
Lazy Eye:
Color Blindness:
Glaucoma:
Cancer:
High Blood Pressure:
Heart Problems:
Diabetes:
Other:

School History

Age at time of entrance:	Have any grades been repeated?	If so, which grade(s)?
Does the child/ student like school?	Is school work? Better than average Average Less than average	
Have there been any school difficulties?	If so, please explain:	
Which subject does the child/ student consider the hardest?	Easiest?	
What are the child's/ student's favorite activities?		
How much TV does the child/ student watch daily?		
How many hours daily does the child/ student play video games?		
What is the average amount of time spent on a computer?		
Does the child/ student have any special abilities (art, music, sports, etc.)		

Developmental History

If you are a parent filling out this form for your child, please provide the following information to the best of your knowledge.

Full-term pregnancy? Yes / No	If no, how many weeks?		
Normal pregnancy and birth? Yes / No	If no, please list complications?		
Please list at which age the child:	Crawled:	Walked:	Talked:
Which hand does the child/ student prefer to use? Right Left			
Was handedness ever change? Yes / No	If so, please explain:		
Under tension is there any pattern of behavior? (thumb sucking, etc.):			

Athletic Performance

Participate in Athletics? Yes / No

Which sports do you play?
Which events/ positions?
Is sports performance variable, especially with increased pressure or fatigue?
Is concentration lost during sports performance? Yes / No
Rate how important you feel vision is in competition (1 being the lowest, 10 being the highest) 1 2 3 4 5 6 7 8 9 10