



CHILD'S GIVEN NAME/S: _____ SURNAME: _____

PARENT/S NAME/S: _____

ADDRESS: _____ SUBURB: _____ POSTCODE: _____

SCHOOL: _____ DATE OF BIRTH: _____ / _____ / _____ SEX: Male Female

GRADE: _____ HOME PHONE: _____ MOBILE: _____

TEACHER'S NAME: _____ EMAIL: _____

GP's NAME: _____ GP's ADDRESS: _____

Developmental History

	Birth Weight	Birth Order eg. First child, second, twin
	Yes No	
Did child come when expected	<input type="checkbox"/> <input type="checkbox"/>	Premature <input type="checkbox"/> Overdue <input type="checkbox"/>
Did child have normal delivery	<input type="checkbox"/> <input type="checkbox"/>	Caesarean <input type="checkbox"/> Forceps <input type="checkbox"/>
Was child well after birth?	<input type="checkbox"/> <input type="checkbox"/>	Humidicrib <input type="checkbox"/> Phototherapy for jaundice <input type="checkbox"/>
Was mother well during pregnancy?	<input type="checkbox"/> <input type="checkbox"/>	Any medication? <input type="checkbox"/> Smoker <input type="checkbox"/>
Did child gain weight normally?	<input type="checkbox"/> <input type="checkbox"/>	Did child bottom shuffle? Yes <input type="checkbox"/> No <input type="checkbox"/>
When did child say first words? months	At what age could child do up buttons?
When did child first speak in sentences? months	At what age could child tie shoe laces?
When did child correctly name colours? years	At what age could child use scissors?
What is child's preferred hand? Right <input type="checkbox"/> Left <input type="checkbox"/>		At what age did child definitely become right or left handed?
Do you consider child's general co-ordination to be as expected for age? Yes <input type="checkbox"/> No <input type="checkbox"/>	 months

General Health

Has child had any serious illness or injury requiring hospitalisation? Yes No If yes, details please.....

Has child had any episode of high fever for more than 48 hours? Yes No If yes, details please.....

Has child a history of recurrent ear problems? Yes No Have tubes been inserted? Yes No

Does child suffer from any other chronic or recurrent illness (eg. asthma, epilepsy) Yes No If yes, details please.....

Has child been diagnosed with Attention Deficit Disorder (ADD)? Yes No

Has child had: speech therapy? Yes No Occupational therapy? Yes No

Does child take any medication? Yes No If yes, please list

Does child live with both parents? Yes No

Visual History

	Yes	No	
Does one eye turn in or out?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when was this first noticed?.....
How often is turn noticed?.....			When is turn noticed? (eg when eating, drawing).....
Has child had a previous visual examination?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when was the last exam?.....
Were glasses prescribed?	<input type="checkbox"/>	<input type="checkbox"/>	
Has patching of one eye been prescribed?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how long was patch worn?
Does child dislike bright light especially when outside?	<input type="checkbox"/>	<input type="checkbox"/>	Does child screw up one eye when in bright light? Yes <input type="checkbox"/> No <input type="checkbox"/>

Educational History

	Yes	No		Yes	No
Has child's school progress been as expected for ability?	<input type="checkbox"/>	<input type="checkbox"/>	Has child repeated a grade?	<input type="checkbox"/>	<input type="checkbox"/>
Does child have difficulty with – reading?	<input type="checkbox"/>	<input type="checkbox"/>	Has there been any remedial teaching?	<input type="checkbox"/>	<input type="checkbox"/>
- writing?	<input type="checkbox"/>	<input type="checkbox"/>	School based	<input type="checkbox"/>	<input type="checkbox"/>
- spelling?	<input type="checkbox"/>	<input type="checkbox"/>	Private tutor	<input type="checkbox"/>	<input type="checkbox"/>
- maths?	<input type="checkbox"/>	<input type="checkbox"/>			

Observable behaviours possibly related to vision problems.

Please tick the box next to any problem that seems to occur often for your child.

Signs of Focusing and Eye Teaming Problems

- | | | | |
|--|--------------------------|--|--------------------------|
| Covers or closes one eye when reading | <input type="checkbox"/> | Complains of words moving on the page | <input type="checkbox"/> |
| Complains of eye strain | <input type="checkbox"/> | Inattentive | <input type="checkbox"/> |
| Complains of headache | <input type="checkbox"/> | Poor reading comprehension | <input type="checkbox"/> |
| Complains of double vision | <input type="checkbox"/> | Loses place when reading | <input type="checkbox"/> |
| Complains of blurred vision when reading | <input type="checkbox"/> | Complains of blurred vision looking from desk to board | <input type="checkbox"/> |
| Rubs eyes | <input type="checkbox"/> | Holds books very close | <input type="checkbox"/> |

Signs of Tracking Problems

- | | | | |
|-----------------------------|--------------------------|-----------------------------------|--------------------------|
| Loses place often | <input type="checkbox"/> | Uses finger to keep place | <input type="checkbox"/> |
| Skips words and lines often | <input type="checkbox"/> | Short attention span when reading | <input type="checkbox"/> |

Signs of Visual Processing Disorders

- | | | | |
|---|--------------------------|--|--------------------------|
| Trouble learning left and right | <input type="checkbox"/> | Untidy writing | <input type="checkbox"/> |
| Reverses letters and numbers | <input type="checkbox"/> | Trouble copying from board to book | <input type="checkbox"/> |
| Mistakes words with similar beginnings | <input type="checkbox"/> | Doesn't recognise the same word on a repeated page | <input type="checkbox"/> |
| Poor recall of visually presented material | <input type="checkbox"/> | Trouble with spelling and sight word vocabulary | <input type="checkbox"/> |
| Slow copying and completing worksheets | <input type="checkbox"/> | Seems to know material, but does poorly on tests | <input type="checkbox"/> |
| Can respond orally but not in writing | <input type="checkbox"/> | Erases excessively | <input type="checkbox"/> |
| Trouble learning basic maths concepts of size and magnitude | <input type="checkbox"/> | Poor reading comprehension yet good comprehension when reading | <input type="checkbox"/> |

HOW DID YOU FIRST HEAR ABOUT OUR PRACTICE?

Personal recommendation of:

(Please name the person we can thank for recommending you to our practice!)

- | | | |
|---|--------------|--|
| <input type="checkbox"/> Friend or Relative | Who: _____ | <input type="checkbox"/> Yellow Pages |
| <input type="checkbox"/> Health Care Practitioner | Who: _____ | <input type="checkbox"/> Yellow Pages Online |
| <input type="checkbox"/> Previous patient | Who: _____ | <input type="checkbox"/> White Pages |
| <input type="checkbox"/> Community Event | Which: _____ | <input type="checkbox"/> White Pages Online |
| <input type="checkbox"/> Teacher | Who: _____ | |
| <input type="checkbox"/> Other: _____ | | |

DO YOU HAVE HEALTH FUND EXTRAS (OPTICAL COVER)?

Yes No

Health Fund Name: _____

YOUR PRIVACY

At Total Optical your privacy is our priority. Your personal information that we collect and hold about you is handled with the utmost confidentiality and security and in accordance with the Privacy Act. For more information on how we manage your privacy, or for a copy of our privacy policy, please contact our practice.

From time to time we may send you information on education relating to eye care and diseases, promotional offers and invitations to events and our practice newsletter. Do we have your permission to send this material to you? YES NO

I authorise that all the information I have provided you is correct. I consent to the release of confidential information from my child's medical records in the understanding that this will be done for the benefit of my child's visual or medical welfare.

Signature: _____

Date: _____