Child Medical History Form

AGE 12 AND UNDER

NAME_____ **DOB**_____ **Today's Date**_____

Does your child have any allergies to medications or non-medication? □ No □ **Yes** **If yes, please list**: _____

_____

List any medications your child takes (including over the counter medications and home remedies): □ NONE

_____

Any family history of eye disease (ie: Glaucoma, Macular Degeneration, etc) (What and who)?

_____

Has your child been diagnosed as having:

□ Asthma □ Autism □ADD or ADHD □ Cerebral Palsy □ Seizure disorder

□ Developmental delays □ Hay Fever □ Learning Disabilities □ Other Problems: _____

Were there any complications with your child during childbirth? □Yes □ No. If yes please explain._____

Have you ever noticed the following:	Y	N	When?
Confuses letters or words	□	□	_____
Reverses letters or words	□	□	_____
Skips, rereads, or omits words	□	□	_____
Reads slowly	□	□	_____
Difficulty distinguishing color	□	□	_____
Writes or prints poorly	□	□	_____
Tires easily	□	□	_____
Avoids near tasks	□	□	_____
Poor motor coordination	□	□	_____
Difficulty catching/hitting a ball	□	□	_____

Television viewing: How much:_____ How Often: _____ Viewing distance:_____

Computer Use: How much:_____ How Often:_____Viewing Distance:_____