Virginia Neuro-Optometry

3721 Westerre Parkway, Suite B
Richmond, VA 23233
Phone : (804) 387-2902
Fax : (804) 509-0543

Pediatrics History Form

Reason for testing: Please describe what brings you in/who referred you for an examination today and any pertinent history:

What are your main visual concerns that are bringing you in?

Goals for testing: What are your goals with the testing (ie oculomotor examination, vision therapy for binocular vision disorder, understand what my child can and cannot see, etc)?

Birth/Developmental History: Please list any abnormalities/complications that may have occurred during pregnancy, delivery (C-Section), early childhood development etc. If normal, write "normal"

Does the patient have any PERSONAL history of:

- □ Strabismus/amblyopia/patching
- □ Eye muscle (Strabismus) surgery
- □ Vision therapy
- □ Wearing glasses at a very young age
- □ Head trauma
- □ Brain injury/concussion
- □ Automobile Accident
- □ Seizures as a child
- □ High Fevers as a child
- □ Learning Disorders: ___________________

Does the patient have any FAMILY eye history of:

- □ Strabismus (eye turn)
  - – if yes, who? ________________
- □ Amblyopia
  - – if yes, who? ________________
- □ Patching
  - – if yes, who? ________________
- □ Vision Therapy
  - – if yes, who? ________________
- □ Learning disorders
  - – if yes, who? ________________
- □ Vision Therapy
  - – if yes, who? ________________

School Information:

School Name: _____________________________ Type (Public/Private, etc):____________________

School Location: ___________________________ Grade Level:____________

Resources: □ 504 plan □ IEP (Individualized Education Program) □ Other ________________

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Subjects: Please list any specific subjects that your child is below grade level in and any specific areas or academic skills your child is experiencing difficulty with?

Vision Symptoms: Please mark (x) each symptom experienced currently

Visual Clarity	□ Blurry vision at distance with head stable □ Blurry vision at distance with head moving □ Blurry vision at near □ Blurry vision fluctuates throughout the day □ Reduced vision at night
Double Vision	□ Double vision is horizontal – two images side by side □ Double vision is vertical – two images up and down □ Double vision is at distance □ Double vision is at near
Visual Tasks Provoke Physical Symptoms of	□ Headaches □ Dizziness □ Nausea □ Brain fog – confusion, disorientation □ Fatigue □ Eye pain □ Eye strain
Light Sensitivity to	□ Normal indoor lighting □ Fluorescent indoor lighting □ Outdoor sunlight □ Electronics/screens □ Flashing/strobing/flickering lights
Dry Eye Symptoms	□ Vision/light sensitivity worse in the morning □ Vision/light sensitivity worse in the afternoon □ Eyes sting/burn/feel dry □ Eyes are red □ Eyes water
Depth Perception	□ Clumsiness/misjudge where objects really are in space □ Lack of confidence walking, missing steps, stumbling □ Poor Handwriting (spacing, size, legibility)
Peripheral vision	□ Side vision is distorted/objects move or change position □ Missing piece/part of peripheral vision □ Difficulty with visual motion □ Carsickness □ Flashes of light □ Floaters
Visual Processing	□ Anxiety in visually crowded areas (restaurants, grocery stores) □ Difficulty with visual search tasks (ex: can't find the milk in the fridge) □ Difficulty concentrating on a task □ Poor ability to organize work □ Confusion following a series of verbal instructions □ Confusion following a series of written instructions □ Confusion with directional orientation/maps/planning in space □ Difficulty with memory

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CISS: In regards to symptoms when reading or doing close/computer work:

	Never	Rarely	Sometimes	Frequently	Always
□ Eyes feel tired	□ 0	□ 1	□ 2	□ 3	□ 4
□ Eyes feel uncomfortable	□ 0	□ 1	□ 2	□ 3	□ 4
□ Eyes feel sore	□ 0	□ 1	□ 2	□ 3	□ 4
□ Eyes hurt	□ 0	□ 1	□ 2	□ 3	□ 4
□ Feel a "pulling" feeling around the eyes	□ 0	□ 1	□ 2	□ 3	□ 4
□ Get headaches	□ 0	□ 1	□ 2	□ 3	□ 4
□ Feel sleepy/tired	□ 0	□ 1	□ 2	□ 3	□ 4
□ Lose concentration	□ 0	□ 1	□ 2	□ 3	□ 4
□ Have trouble remembering what you read	□ 0	□ 1	□ 2	□ 3	□ 4
□ Have double vision	□ 0	□ 1	□ 2	□ 3	□ 4
□ Words move, jump, swim, or float on the page	□ 0	□ 1	□ 2	□ 3	□ 4
□ Read slowly	□ 0	□ 1	□ 2	□ 3	□ 4
□ Words blur or come in and out of focus	□ 0	□ 1	□ 2	□ 3	□ 4
□ Lose your place	□ 0	□ 1	□ 2	□ 3	□ 4
□ Have to re-read the same line of words	□ 0	□ 1	□ 2	□ 3	□ 4

Behavior Symptoms: Please mark (x) each symptom experienced currently

	Never	Rarely	Sometimes	Frequently	Always
□ Hyperactive	□ 0	□ 1	□ 2	□ 3	□ 4
□ Easily distracted	□ 0	□ 1	□ 2	□ 3	□ 4
□ Short attention span	□ 0	□ 1	□ 2	□ 3	□ 4
□ Easily frustrated	□ 0	□ 1	□ 2	□ 3	□ 4
□ Impulsive	□ 0	□ 1	□ 2	□ 3	□ 4
□ Easily fatigued	□ 0	□ 1	□ 2	□ 3	□ 4
□ Poor ability to organize work	□ 0	□ 1	□ 2	□ 3	□ 4
□ Indistinct speech	□ 0	□ 1	□ 2	□ 3	□ 4
□ Awkward or clumsy	□ 0	□ 1	□ 2	□ 3	□ 4
□ Behavior problems	□ 0	□ 1	□ 2	□ 3	□ 4
□ Emotional problems	□ 0	□ 1	□ 2	□ 3	□ 4
□ Confusion following a series of verbal instructions	□ 0	□ 1	□ 2	□ 3	□ 4
□ Confusion following a series of written instructions	□ 0	□ 1	□ 2	□ 3	□ 4
□ Reverses letters, words, or numbers in reading	□ 0	□ 1	□ 2	□ 3	□ 4
□ Reverses letters, words, or numbers in writing	□ 0	□ 1	□ 2	□ 3	□ 4
□ Confuses left and right	□ 0	□ 1	□ 2	□ 3	□ 4
□ Confusion with directional orientation/maps	□ 0	□ 1	□ 2	□ 3	□ 4

Anything else you would like us to know/evaluate?