Developmental History

Berkeley School of Optometry

Child's Name: _____ Birthday: ____/____/____ Age: _____ Grade: _____

Parent/Guardian(s) Name: _____ Occupation: _____ Phone: _____

Parent/Guardian(s) Name: _____ Occupation: _____ Phone: _____

Who referred you to this clinic/Relationship to patient? _____ # of children in family: _____

I. Please state the major reason you would like your child examined:

_____

II. Vision (Please place a check in the appropriate box)

	NEVER 0	RARELY 1	OCCASIONALLY 2	FREQUENTLY 3	ALWAYS 4
Do your eyes feel tired when reading or doing close work?	☐	☐	☐	☐	☐
Do your eyes feel uncomfortable when reading or doing close work?	☐	☐	☐	☐	☐
Do you have headaches when reading or doing close work?	☐	☐	☐	☐	☐
Do you feel sleepy when reading or doing close work?	☐	☐	☐	☐	☐
Do you lose concentration when reading or doing close work?	☐	☐	☐	☐	☐
Do you have trouble remembering what you have read?	☐	☐	☐	☐	☐
Do you have double vision when reading or doing close work?	☐	☐	☐	☐	☐
Do you see the words move, jump, swim, or appear to float on the page when reading or doing close work?	☐	☐	☐	☐	☐
Do you feel like you read slowly?	☐	☐	☐	☐	☐
Do your eyes ever hurt when reading or doing close work?	☐	☐	☐	☐	☐
Do your eyes ever feel sore when reading or doing close work?	☐	☐	☐	☐	☐
Do you feel a "pulling" feeling around your eyes when reading or doing close work?	☐	☐	☐	☐	☐
Do you notice the words blurring or coming in and out of focus when reading or doing close work?	☐	☐	☐	☐	☐
Do you lose your place while reading or doing close work?	☐	☐	☐	☐	☐
Do you have to re-read the same line of words when reading?	☐	☐	☐	☐	☐
Do you ever experience blurred distance vision?	☐	☐	☐	☐	☐
Do you ever hold reading material closer than normal?	☐	☐	☐	☐	☐
Do you have double vision at distance?	☐	☐	☐	☐	☐
Do you have an eye turn? (Crossed or wall-eyed)	☐	☐	☐	☐	☐
Do you blink excessively?	☐	☐	☐	☐	☐
Do you cover one eye while doing homework?	☐	☐	☐	☐	☐

III. Behavior (Please place a check in the appropriate box)

	NEVER 0	RARELY 1	OCCASIONALLY 2	FREQUENTLY 3	ALWAYS 4
Hyperactive	☐	☐	☐	☐	☐
Easily distracted	☐	☐	☐	☐	☐
Short attention span	☐	☐	☐	☐	☐
Easily frustrated	☐	☐	☐	☐	☐
Impulsive	☐	☐	☐	☐	☐
Easily fatigued	☐	☐	☐	☐	☐
Poor ability to organize work	☐	☐	☐	☐	☐
Indistinct speech	☐	☐	☐	☐	☐
Awkward or clumsy	☐	☐	☐	☐	☐
Behavior problems	☐	☐	☐	☐	☐
Emotional problems	☐	☐	☐	☐	☐
Confusion following a series of verbal instructions	☐	☐	☐	☐	☐
Variable school performance (from hour to hour/ day to day)	☐	☐	☐	☐	☐
Reverses letters, words, or numbers in reading	☐	☐	☐	☐	☐
Reverses letters, words, or numbers in writing	☐	☐	☐	☐	☐
Shows confusion about right or left	☐	☐	☐	☐	☐
Shows confusion about directional orientation	☐	☐	☐	☐	☐

IV. School Information:

School Name: _____ Address: _____

Resources/Accommodations	NO	YES	IF YES, SINCE WHEN AND FOR WHAT AREAS?
504 Plan in place?	☐	☐	
IEP (Individualized Education Program) in place?	☐	☐	

Progress: Rate your child's progress in the following subjects (Please place a check in the appropriate box & any comments)

Subject	ABOVE GRADE LEVEL	AT GRADE LEVEL	BELOW GRADE LEVEL	*What specific areas or academic skills is your child experiencing difficulty with? Comments:*	*Any family member with learning difficulties? Please indicate subject and relationship to child.*
Reading	☐	☐	☐		
Spelling	☐	☐	☐		
Writing	☐	☐	☐		
Arithmetic	☐	☐	☐		
Art	☐	☐	☐		
Music	☐	☐	☐		
Phys. Education	☐	☐	☐		
Other? Please list:	☐	☐	☐		

V. General Health and Developmental History:

	NO	YES	IF YES, PLEASE EXPLAIN:
Any severe childhood illness, high fever, injury, or physical impairment?	☐	☐	
Any diagnosed hearing impairment?	☐	☐	*Date of last hearing test:*
Any diagnosed speech/ language deficiency?	☐	☐	*Date of speech/language evaluation:*
Any diagnosed visual problems?	☐	☐	*Date of last eye exam:*
Any allergies?	☐	☐	
Any medications and/or vitamins?	☐	☐	*Please list, including purpose, dosage, duration of treatment:*
History of previous (or current) therapy for learning, visual, occupational, physical, and/ or speech difficulties?	☐	☐	*Please list, including type of therapy, duration, and results:*

VI. Pregnancy & Birth History:

	YES	NO	COMMENTS:
Normal pregnancy?	☐	☐	
Normal birth history?	☐	☐	
Normal gestation time	☐	☐	If premature, number of weeks?
Normal birth weight	☐	☐	Lbs: _____ Oz: _____ Current weight: Lbs: _____ Height: _____ft _____in
Normal Apgar score	☐	☐	Score: _____

VII. Developmental Milestones:

	YES	NO	IF NO, WHEN?
Turned head to locate sound by 6 months	☐	☐	
Followed simple instructions by age 2 yrs	☐	☐	
Said first word at 12 months	☐	☐	
Used sentences of more than three words by age 4 yrs	☐	☐	
Reached for objects by 7 months	☐	☐	
Searched for objects that are hidden while watching by 12 months (Ex: Peek-a-boo)	☐	☐	
Copied a circle by age 4 yrs	☐	☐	
Grasped a crayon between thumb & finger by age 4	☐	☐	
Walked unaided by 18 months	☐	☐	
Jumped in place by age 4 yrs	☐	☐	

Signature: _____ Date: _____

Relationship to Child: _____ Parent/Guardian email address: _____

Thank you!