
Preschool Vision Form

Preschool - ages 3, 4 and 5



Patient's Name: _____ Date: _____

Date of Birth: _____

Name of Parent or Guardian: _____

Primary Care Doctor : _____

Has your child been diagnosed with or suspected of having any of the following conditions?

(If yes, check the appropriate box)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Epilepsy or seizure | <input type="checkbox"/> Developmental Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Pre-Mature Birth | <input type="checkbox"/> Trauma at birth |
| <input type="checkbox"/> Frequent Ear Infection | | | |

Has your child received special testing? _____

Has your child had any Previous vision care? Yes No

Describe any difficulty your child had in learning motor skills (walking, skipping) or language skills:

(Continued on the next page...)

CHECK THE COLUMN WHICH BEST REPRESENTS THE OCCURRENCE OF EACH SYMPTOM:

| | Never (0) | Seldom (1) | Occasionally (2) | Frequently (3) | Always (4) |
|----------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Frequent Headaches | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Burn,Itchy,Watery Eyes | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Head tilt when reading | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Closes One Eye | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Avoids Near Work | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Close Working Distance | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Poor Coordination | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Squinting | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Short Attention Span | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Poor Eye/Hand Coordination | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Frowning or Blinking | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Eye Turn | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Rubs Eyes | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Red Eyes | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Difficulty Catching Ball | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

For Office Use Only:

Total for all
(Except Never Category)