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# Youth Vision Form

Ages 6 to 18



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Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Parent or Guardian: \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_

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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"/> Learning Disability | <input type="checkbox"/> Trauma at birth        |
| <input type="checkbox"/> Frequent Ear Infection |                                        |                                              |                                                 |

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Child's age upon entrance into Kindergarten: \_\_\_\_\_ Has a grade been repeated \_\_\_\_\_

Are you concerned about your child's school performance? \_\_\_\_\_ Is the school? \_\_\_\_\_

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In your opinion, how is your child's performance in the following?

	<i>Good</i>	<i>Average</i>	<i>Poor</i>		<i>Good</i>	<i>Average</i>	<i>Poor</i>
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has your child been enrolled in extra classes? Yes No

Has your child received special tutoring outside of school? Yes No

Has your child received special testing? Yes No

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:

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(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)
Headaches with near work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Words run together when reading	<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"/>
Skips/repeats lines when reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty copying from chalkboard	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Head tilt/closes one eye when reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Omits small words when reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Avoids near work/reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Writes up/down hill (Difficulty writing on the line)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Misaligns digits/columns or numbers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor reading comprehension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Holds reading too close	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty completing assignments on time	<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"/>
Letter/number reversal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor spacing when writing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Uses finger as a marker	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor hand-eye 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"/>
Poor/inconsistent in sports	<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"/>

For Office Use Only:

                      

**Total for all**  
(Except Never Category)