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)

- ☐ Allergies
- ☐ Head Trauma
- ☐ Epilepsy or seizure
- ☐ Developmental Disorder
- ☐ Asthma
- ☐ Hyperactivity
- ☐ Pre-Mature Birth
- ☐ Trauma at birth
- ☐ 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:

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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)
Frequent Headaches	O	O	O	O	O
Burn,Itchy,Watery Eyes	O	O	O	O	O
Head tilt when reading	O	O	O	O	O
Closes One Eye	O	O	O	O	O
Avoids Near Work	O	O	O	O	O
Close Working Distance	O	O	O	O	O
Poor Coordination	O	O	O	O	O
Squinting	O	O	O	O	O
Short Attention Span	O	O	O	O	O
Poor Eye/Hand Coordination	O	O	O	O	O
Frowning or Blinking	O	O	O	O	O
Eye Turn	O	O	O	O	O
Rubs Eyes	O	O	O	O	O
Red Eyes	O	O	O	O	O
Difficulty Catching Ball	O	O	O	O	O

For Office Use Only:

Total for all
(Except Never Category)