learn to see
vision clinic

Welcome to our office!

Please fill out the background history form *as completely as possible* and return to the office **before** your appointment**. Thank you!**

Name ______________________________Birth date____/____/_______ Age______ Grade______

Mailing Address____

City, State____Zip_______________

Home Phone_______________________________ Cell Phone_______________________________

Please Indicate Preferred Number (Home, Work, or Cell)

Email Address____

Parents Names Occupation Work Phone

1. ____

2. ____

Others living at home with your child ____

____

How did you hear about our office?____

Vision History

In what ways does your child seem to have difficulty? ___________________________________

____

How does your child complain about his or her vision? __________________________________

____

Previous visual examinations (list reason for exams and results)__________________________

____

Have any other family members had vision concerns? Please describe.__________________

____

Developmental and Health History

Was pregnancy full-term?__________________ Any complications before, during or after the birth?____

Anything unusual about your child's development?____________________________________

____

Developmental Milestones- Please circle one early - late - on time

Crawling early - late - on time Walking early - late - on time

First Words early - late - on time Sentences early - late - on time

Hand used for writing? ______________ Any tasks he or she uses the opposite hand or foot?

____

Medications________________________Allergies____

List any history of illnesses, surgeries, or accidents (including ear infections) _____________

____

Is there a family history of learning difficulties?____

____

School History

Age at time of entrance?_________ Was a grade repeated?___________________________

Does your child like school?____

Have there been any school difficulties?____

____

What subjects are considered easiest? ____________________ Hardest?__________________

List any special testing and the results? Please include copies if possible. ______________

____

Has your child received any additional tutoring or special education assistance? ______

____

2500 34th Avenue S Minneapolis, MN 55406 612-724-5125 f:651-389-9295 DrLes@learntosee.org

General Information

Describe your child.____

____

Child's interests____

Child's response to stress or fatigue____

Is there anything you wish to discuss when your child is not present?________________

____

Symptoms Checklist--Please check all that apply

- o Headaches
- o Blurred vision
- o Double vision
- o Eyes "hurt" or "tired" when reading
- o Frequent eye rubbing or blinking
- o Light sensitivity
- o Closing or covering one eye while reading
- o Head close to paper when reading or writing
- o Tilting head when reading or writing
- o Moves head when reading
- o Confuses letters, words, or numbers
- o Reverses letters, words or numbers
- o Skips or rereads words or lines
- o Reads slowly
- o Uses finger as marker
- o Loses place while reading
- o Poor reading comprehension
- o Words become jumbled or move
- o Becomes sleepy while reading
- o Avoids near tasks
- o Short attention span
- o Poor motor coordination / clumsy
- o Difficulty catching or hitting a ball
- o Carsickness
- o Confuses right and left
- o Poor spelling
- o Poor handwriting
- o Makes errors copying from a board
- o Eye turns in or out
- o Difficulty following directions
- o "Loves to be read to, hates to read

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Permission for Release of Information

In an effort to communicate with the professionals who care for your child's health, wellness, and education, the Learn to See Vision Clinic would like to send copies of your child's vision evaluation and follow up reports to any of the following professionals. Please include anyone else involved with your child whom you would like to receive a report.

Please provide the name, address, phone, fax and email of the professionals for which you permit reports to be sent. Complete information is required to ensure we can best serve you. Thanks!

- **Name of clinic and primary physician or pediatrician**
  ____
  Phone:________________ Fax:________________
  Mailing Address:______________________________
  Email:______________________________
- **Other medical specialists (optometrist, psychologist, occupational therapist)**
  ____
  Phone:________________ Fax:________________
  Mailing Address:______________________________
  Email:______________________________
- **Name of School and teachers (classroom, special ed.)**
  ____
  Phone:________________ Fax:________________
  Mailing Address:______________________________
  Email:______________________________
- **Educational tutors or others**
  ____
  Phone:________________ Fax:________________
  Mailing Address:______________________________
  Email:______________________________

The Learn to See Vision Clinic also provides school consultations for teachers and participates in IEPs upon parent request.

At any time you have the right to decline the disclosure of your patient health information. At the time of declination the Learn to See Vision Clinic will cease to use your health information unless otherwise required by law. I understand the above and give my permission to disclose my child's health vision evaluation to the appropriate medical and educational professionals.

____
Child's Name (per health and education records)

____
Signature of Parent/ Guardian Date