Berwick Family Eyecare

OPTIMISE
YOUR VISUAL
PERFORMANCE

T (03) 9707 5529
36a Clyde Road Berwick VIC 3806
E reception@berwickfamilyeyecare.com.au
W berwickfamilyeyecare.com.au

This form will give us important information that will help your optometrist to assess your vision. Please return the completed form by email or print and return at your next appointment.

Please fill in the following form to the best of your ability. Your personal information is treated with confidentiality

PRE-EXAM FORM

Patient Details

Patient's Name ..... Date of birth .....

Parents Names .....

Address .....

..... PostCode .....

Email ..... Telephone .....

School ..... Year ..... Teacher .....

Initial Complaint / Major Concern

Please state briefly your main concern / the main problem that your child is having:

.....

.....

When did you first have concerns/notice this problem?

.....

If applicable, please note who referred you to our practice:

.....

Visual History

When was your child's last eye examination?

.....

Please describe any previous visual treatment your child has received (including glasses, vision therapy, eye patches, surgery or medications).

.....

.....

(Please tick the following)

- ☐ Blurred distance vision
- ☐ Eye turn/in/out/up
- ☐ Squints or blinks excessively
- ☐ Words move or run together
- ☐ Avoids close work
- ☐ Uses finger to read
- ☐ Difficulty catching a ball
- ☐ Poor spelling
- ☐ Writes uphill/downhill
- ☐ Behaviour/concentration
- ☐ Blurred near vision
- ☐ Tilts head
- ☐ Red or teary eyes
- ☐ Short attention span
- ☐ Closes one eye when reading
- ☐ Skips or re-reads lines
- ☐ Awkward pencil grip
- ☐ Trouble knowing left from right
- ☐ Poor spacing when writing
- ☐ Omits small words when reading
- ☐ Double vision
- ☐ Frequent headaches
- ☐ Motion/travel sickness
- ☐ Slow reading
- ☐ Holds book too close
- ☐ Poor word recognition
- ☐ Poor reading comprehension
- ☐ Reverses letters and numbers
- ☐ Trouble copying from the board
- ☐ Fatigues easily with near tasks

Educational History

Has your child repeated any grade? If yes, which one?

.....

Is your child receiving any extra help in school or outside of school hours? Please describe:

.....

Please list any evaluations done at school or by school recommendation
(psychological, educational, speech/language, occupational therapy, neurological, medical)
(Please bring copy of reports)

.....

(Please tick the following)

Do you feel your child is performing to his/her potential in school? ☐ Yes ☐ No

Does your child enjoy reading for pleasure ☐ Yes ☐ No

Developmental History

When you were pregnant did you have any medical problems? (Please state)

.....

Was your child delivered at term or ☐ Early ☐ Late

Was your child's birth weight low? ☐ Yes ☐ No

Was the birth process unusual in any way

☐ forceps ☐ suction ☐ C-section ☐ long duration ☐ Other .....

Did your child roll? ☐ Yes ☐ No

Did your child bum shuffle or skip the cross-crawling stage? ☐ Yes ☐ No

Did your child start walking ☐ before 10 months ☐ after 16 months?

Did your child suck their thumb past the age of 5 yrs? ☐ Yes ☐ No

Did your child regularly wet the bed past the age of 5? ☐ Yes ☐ No

If there is a sudden noise, would your child over-react? ☐ Yes ☐ No

Medical History

Name of Doctor (GP) ..... Clinic Name & Address: .....

.....

If you have a Pension Card/Healthcare Card or Veterans' Card please present it at reception with your Medicare Card.

Did your child experience any serious illness or seizures in the first 18 months of life?

.....

Please list any past or current severe illnesses, injuries or physical impairment

.....

Please list any medication your child is taking: .....

.....

Please list any significant allergies your child has: .....

Does your child suffer from eczema or asthma: .....

NUTRITION

Does your child display; Fussy eating or selective eating habits ☐ Yes ☐ No

Likes sugary foods all the time ☐ Yes ☐ No

Is affected by chemicals in food like food colours or preservatives ☐ Yes ☐ No

Family History

Does anyone in the family have any of the following? (Please tick)

☐ Myopia (Shortsighted) ☐ Astigmatism ☐ Eye Disease

☐ Hyperopia (longsighted) ☐ Amblyopia (Lazy eye) ☐ Turned Eye