



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)

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