ORANGEVILLE VISION DEVELOPMENT CENTRE

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LEARNING RELATED VISION PROBLEMS

PATIENT INFORMATION

Name: _____ ☐ Male ☐ Female

Date of Birth: _____ (M/D/Y) Age: _____ Home Phone: _____

Address: _____

City: _____ Postal Code: _____

Parent's Names _____ & _____

Parent's Cell Number _____ & _____

Email: _____ Referred by: _____

Health Card #: _____ VC_____

Last Eye Exam: _____ Optometrist: _____

Optometrist's Phone Number:_____ Fax Number:_____

Grade: _____ School: _____

Individualized Education Program: ☐ **Yes** ☐ **No**

HEATH HISTORY

Family Doctor: _____

Family Doctor's Phone Number:_____ Fax Number:_____

Please list any current medical conditions: _____

Past surgical history: _____

Medications: _____

Allergies: _____

Are you generally healthy? ☐ **Yes** ☐ **No**

Is there a history of bad fall(s) that resulted in a head injury? ☐ **Yes** ☐ **No**
If Yes, was it considered Mild, Moderate or Severe: _____

Is there a history of high fevers? ☐ **Yes** ☐ **No**
If Yes, was it considered Mild, Moderate or Severe: _____

What was the frequency of the fevers? _____

Is there a history of chronic ear infections? ☐ **Yes** ☐ **No**
If Yes, was it considered Mild, Moderate or Severe: _____

Have you ever had surgery to treat ear infections? ☐ **Yes** ☐ **No**

Has any neurological and/or psychological evaluation been performed?

- ☐ Yes
- ☐ No

Any current or past Occupational, Physical and/or Speech Therapy?

- ☐ Yes
- ☐ No

Is your child performing below, above or at grade level for knowing numbers/letters, writing and reading? _____

_____

OCULAR HISTORY

Any history of the following?	Patient	Family	COMMENT
Eye Turn (Strabismus)	☐	☐	_____
Lazy Eye (Amblyopia)	☐	☐	_____
Double Vision (Diplopia)	☐	☐	_____
High Prescription	☐	☐	_____
Learning Disabilities	☐	☐	_____
Eye Shake (Nystagmus)	☐	☐	_____
ADD/ADHD	☐	☐	_____
Autism	☐	☐	_____

Does the patient wear glasses?

- ☐ Yes
- ☐ No

If Yes, at what age was the first pair of glasses prescribed?

_____

Are the glasses worn part time or full time?

- ☐ Part time
- ☐ Full time

The glasses are worn to correct…

- ☐ Near Vision
- ☐ Distance Vision
- ☐ Both

Are there prisms in the current glasses?

- ☐ Yes
- ☐ No

EYE TURN HISTORY

At what age did the eye turn start?_____

Is there a history of wearing an eye patch as prescribed by a professional?

- ☐ Yes
- ☐ No

If YES, how many hours a day was the patch worn? _____

How many times a week? _____

Is the patient seeing an eye surgeon/ophthalmologist? Who?

_____

What are the results/ recommendations by the ophthalmologist?

_____

Has the patient had eye muscle surgery? If Yes, when?

_____

How long after the last surgery did the eye begin turning again?

_____

Which eye is turning?

_____

Does the eye turn in, out, up or down?

_____

SYMPTOMS

Physical Signs / Complaints	YES	NO	COMMENT
Bumps into objects/clumsy	☐	☐	_____
Avoidance/poor focus with near work/reading	☐	☐	_____
Headaches around eyes/forehead	☐	☐	_____
Head turn or tilt	☐	☐	_____
Hold reading material too close	☐	☐	_____
Skips words or lines when reading	☐	☐	_____
Trouble catching a ball	☐	☐	_____
Closes/covers an eye during deskwork	☐	☐	_____
Difficulty judging distances	☐	☐	_____

- ☐ **I GIVE** ORANGEVILLE VISION DEVELOPMENT CENTRE TO EMAIL ME WITH MEDICAL REPORTS, EDUCATION & PERSONAL COMMUNICATIONS
- ☐ **I DO NOT GIVE** ORANGEVILLE VISION DEVELOPMENT CENTRE PERMISSION TO EMAIL ME WITH MEDICAL REPORTS, EDUCATION, PERSONAL COMMUNICATIONS & PROMOTIONS

_____ Signature

_____ Date