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Your child's vision may be affected by the following conditions. Please take a few moments to answer these questions:

**General Information:**

CHILD'S FULL NAME \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Mother's name \_\_\_\_\_ Age \_\_\_\_\_

Father's name \_\_\_\_\_ Age \_\_\_\_\_

Brothers and sisters (please list ages also) \_\_\_\_\_  
\_\_\_\_\_

**Medical History:**

Most recent medical examination:

Doctors name: \_\_\_\_\_ Date \_\_\_\_\_

Results: \_\_\_\_\_

Medications currently using: \_\_\_\_\_

For what conditions: \_\_\_\_\_

Birth weight: \_\_\_\_\_

Did the mother experience any health problems during the pregnancy, especially during the first trimester? \_\_\_\_\_

If yes, explain: \_\_\_\_\_

List illnesses, bad falls, high fevers, etc.:

<u>Age</u>	<u>Illness</u>	<u>Severity</u>	<u>Complications</u>
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Is your child generally healthy? \_\_\_\_\_

Are there any chronic problems like asthma, hay fever, allergies? \_\_\_\_\_

If yes, please list: \_\_\_\_\_

Has a neurological exam been performed? \_\_\_\_\_ By Whom? \_\_\_\_\_

Results: \_\_\_\_\_

Any family history of the following conditions (please circle and indicate whom):

Diabetes	Glaucoma
High blood pressure	Crossed or Lazy Eye
Multiple Sclerosis	Other (Explain)
Chromosomal Imbalance	

**Developmental History:**

Full term pregnancy? \_\_\_\_\_ Normal Birth? \_\_\_\_\_ Any complications before, during or immediately following delivery? \_\_\_\_\_

Was there ever any concern over you child's general growth or development? \_\_\_\_\_  
If yes, why? \_\_\_\_\_

What percent of waking hours is your child in a playpen and/or walker and/or seat? \_\_\_\_\_

What things can you child do very well? \_\_\_\_\_

What things, if any are difficult for your child? \_\_\_\_\_

**Visual History:**

Previous exam date: \_\_\_\_\_ Doctor: \_\_\_\_\_

Reason for exam: \_\_\_\_\_

Results: \_\_\_\_\_ Was therapy recommended? \_\_\_\_\_

What type of therapy? (vision therapy, patching, surgery, glasses, contacts, etc.) \_\_\_\_\_

Members of the family who have had visual attention and why: \_\_\_\_\_

Please circle Y for yes and N for no to the following observations and/or complaints as they relate to your child:

- |   |   |     |                                                                                                                       |
|---|---|-----|-----------------------------------------------------------------------------------------------------------------------|
| Y | N | 1.  | Eyes crossed - turning in our out - at any time, or eyes that do not appear straight, especially when child is tired. |
| Y | N | 2.  | Has reddened eyes or eyelids.                                                                                         |
| Y | N | 3.  | Has encrusted eyelids.                                                                                                |
| Y | N | 4.  | Has frequent sties.                                                                                                   |
| Y | N | 5.  | Eyes in constant motion.                                                                                              |
| Y | N | 6.  | Eyelids droop.                                                                                                        |
| Y | N | 7.  | Complains of headache.                                                                                                |
| Y | N | 8.  | Complains of burning or itching eyes.                                                                                 |
| Y | N | 9.  | Complains of pain in eyes.                                                                                            |
| Y | N | 10. | Stares at bright lights frequently or repeatedly flicks objects in front of face.                                     |
| Y | N | 11. | Is abnormally bothered by bright light.                                                                               |
| Y | N | 12. | Has watery eyes.                                                                                                      |
| Y | N | 13. | Thrusts the head forward or backward while looking at distant objects.                                                |
| Y | N | 14. | Turns the head to use one eye only.                                                                                   |
| Y | N | 15. | Tilts the head to one side.                                                                                           |
| Y | N | 16. | Places an object close to the eyes to look at it.                                                                     |
| Y | N | 17. | Squints while looking at objects.                                                                                     |
| Y | N | 18. | Blinks excessively.                                                                                                   |
| Y | N | 19. | Has a tendency to rub eyes.                                                                                           |
| Y | N | 20. | Covers or closes one eye.                                                                                             |
| Y | N | 21. | Stumbles over objects.                                                                                                |
| Y | N | 22. | Lacks interest in looking at objects or seeing.                                                                       |
| Y | N | 23. | Unable to see distant objects.                                                                                        |
| Y | N | 24. | Transfers object from hand to hand, crossing the middle of the body.                                                  |
| Y | N | 25. | Is unable to stack blocks or other objects.                                                                           |

**Nutritional Information:**

Current Diet (please circle):      Nursing:      Never      Now      Nursed until \_\_\_\_\_  
Solid food started:      What type: \_\_\_\_\_

Activity level (please circle):      High      Moderate      Low  
Are there periods of very high energy? \_\_\_\_\_  
If yes, when? \_\_\_\_\_  
Are there periods of very low energy? \_\_\_\_\_  
If yes, when? \_\_\_\_\_

**Behavior:**

Do you have any concerns about your child's behavior? \_\_\_\_\_

If so, what are they? \_\_\_\_\_

Check the appropriate spaces if you have any concerns about the following behavior(s) in you child.

- |                         |                               |                                                 |
|-------------------------|-------------------------------|-------------------------------------------------|
| _____ lack of curiosity | _____ irritable, easily upset | _____ thumb sucking                             |
| _____ restlessness      | _____ nervous                 | _____ glum, sulky, moody                        |
| _____ bad temper        | _____ sleeplessness           | _____ has difficulty separating<br>from parents |

*Thank you for carefully completing this questionnaire.*

*The information supplied will allow for a more efficient use of time and will permit us to make a more complete evaluation of your child's visual system related to his/her specific needs.*