



YOUNG ADULT HISTORY

Developmental Vision & Rehabilitation

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Name _____

Date _____

Referred by _____

General Information

Home Phone _____ Cell Phone _____

Fax Number _____ E-Mail _____

Home Address _____

City _____ State _____ Zip _____

Social Security Number _____ Age _____

Birth Date _____ Sex *M* *F*

Emergency Contact _____

Name of Health Care Plan? _____

Policy Number _____

Parent Information

Home address _____

City _____ State _____

Zip _____ Home phone _____

Cell phone _____ Fax number _____

Email _____

Father's occupation _____ Employer _____

Work phone _____

Mother's occupation _____ Employer _____

Work phone _____

Do you have a health care plan? _____

If so, name of health care plan? _____

Policy number _____

Visual History

Doctor's name & date _____

Results _____

Were glasses prescribed? _____ Are they worn? _____

When? _____ Any history of crossing eyes? _____

What age first noticed? _____ Any family history of crossing eyes? _____

Who? _____

Other Evaluations

Has a neurological evaluation been performed? _____ By whom? _____

Results: _____

Has a psychological evaluation been performed? _____ By whom? _____

Results: _____

List any other complaints concerning your vision: _____

Health Information

Medications currently taking _____

For what condition? _____

List illnesses, bad falls, head injuries, high fevers etc.

Concussions & when:

Present Situation

Is there any evidence from school or psychological tests that some visual malfunction may be present? _____

If so, what? _____

Do you currently receive:

Occupational therapy services? _____

By whom? _____

Results: _____

Physical therapy services? _____

By whom? _____

Results: _____

Speech therapy services? _____

By whom? _____

Results: _____

Other therapy services? _____

By whom? _____

Results: _____

Vision Health History

Members of the family who have had visual dysfunctions and why:

Name

Age

Visual Situation

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any history of the following, please check:

	You	Family		You	Family
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Eye Turn/Strabismus	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye/Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>
Double-Vision	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Color Deficiency	<input type="checkbox"/>	<input type="checkbox"/>
Learning Problems	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever noticed the following:

Eyes frequently reddened	Yes	No
If so, when? _____		
Frequent eye rubbing	Yes	No
If so, when? _____		
Frequent blinking	Yes	No
If so, when? _____		
Closing or covering one eye	Yes	No
If so, when? _____		
Head close to paper		
when reading or writing:	Yes	No
Tilting head when reading:	Yes	No
Tilting head when writing:	Yes	No
Confuses letters or words:	Yes	No
Reverses letters or words:	Yes	No
Skips, rereads or omits words:	Yes	No
Vocalizes when reading silently:	Yes	No
Reads slowly:	Yes	No
Uses finger as a marker:	Yes	No
Poor reading comprehension:	Yes	No
Writes or prints poorly:	Yes	No
Tires easily:	Yes	No
Avoids near tasks:	Yes	No
Short attention span:	Yes	No

School

Specifically describe any school difficulties: _____

Has a grade been repeated? Yes No

When? _____

Has he/she had any special tutoring and/or

remedial assistance? Yes No

When? _____

From whom? _____

Where? _____

How long? _____

Results: _____