**Vision History Form**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vision history for child listed above:**

1. Does your child wear prescription glasses? 🞏 Yes 🞏 No

2. Is there anyone in the child’s family who had

amblyopia (lazy eye) or any other vision problem 🞏 Yes 🞏 No

that was not caused by an injury to the eye?

3. Is there anyone in the child’s family that had 🞏 Yes 🞏 No

strabismus (crossed eyes)?

4. Was your child born prematurely? 🞏 Yes 🞏 No

5. Has your child ever had an eye injury? 🞏 Yes 🞏 No

4. Does your child frequently complain of headaches? 🞏 Yes 🞏 No

**Vision behaviors for child listed above:**

1. Do your child’s eyes appear unusual? 🞏 Yes 🞏 No

2. Does your child seem to see well? 🞏 Yes 🞏 No

3. Does your child have difficulty with near or 🞏 Yes 🞏 No

distance vision?

4. Do your child’s eyes ever seem to cross? 🞏 Yes 🞏 No

5. Do your child’s eye lids droop? 🞏 Yes 🞏 No

6. Does your child squint when looking at objects? 🞏 Yes 🞏 No

7. Does your child tend to close one eye lid when 🞏 Yes 🞏 No

looking at an object?