Child's Supplemental History

Today's Date:_____

Child's Name:_____

Date of Birth:_____

Parent/Guardian Name:_____

2nd Parent/Guardian Name: _____

Pregnancy Histroy:

1) Pregnancy Complications (such as infections, illnesses, or high risk drugs during pregnancy)? Yes No If yes, please list:

_____

_____

2) Premature Birth? Yes No If yes, how many weeks?_____

3) Any issues during or after birth (such as low APGAR score, extended hospitalization, infections)? Yes No If yes, please list:

_____

_____

4) Any developmental issues (such as delayed speech, crawling, walking)? Yes No If yes, please list:

_____

_____

5) Do you have any concerns or questions about the child's eyes or vision? Yes No If yes, please list:

_____

_____

DILATING DROPS are usually necessary to diagnose your child's condition. They typically cause near vision (such as reading vision) to be blurry for the first two hours, and increased sensitivity to sunlight for most of the day.
Please tell the doctor if your child has an important event (such as the SAT) scheduled the same day as your exam so we can reschedule the dilation.

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