Neuro-Developmental Eye Consultants-Charles Shidlofsky, O.D.

Dallas/Odessa 972-312-0177

GENERAL INFORMATION

Were you referred? Yes ____ No ____

If yes, by whom? ________________________________ **Phone:** _________________

Address: ____

Child's Full Name: ______________________________________ Male _____ Female _____

Birth Date: ____________________________________ Age: _____years _____months

Name and address of school: ____

Grade: ____ Teacher: _________________________

Is your child especially afraid of doctors? _______________________

Childs handedness: righ**t or** lef**t?** ______________________

HOME: Father __________________________________ Birth Date: ______________

Mother _________________________________ Birth Date: ______________

Brothers ________________________________ Birth Date: ______________

AND ________________________________ Birth Date: ______________

Sisters _________________________________ Birth Date: ______________

PARENT INFORMATION

Home Address ____________________________ **City** _______________ **Zip** __________

Email ___________________________________ **Home Phone** _______________________

Father's Occupation ______________________ **Business Phone** _____________________

Mother's Occupation _____________________ **Business Phone** _____________________

Social Security Number: __________________ **Drivers License #** ___________________

Major Medical Policy (if applicable) : Carrier _________________ **Policy #** _____________

MEDICAL HISTORY

Physician's Name _________________________________ Date of Last Visit _______________

Results ____

Medications currently using ____

For what condition? ____

Any history in your family of the following:

Diabetes: Yes ____ No _____ Glaucoma: Yes _____ No _____

High Blood Pressure: Yes _____ No _____ Macular Degeneration: Yes ____ No _____

Any Illnesses, bad falls, high fevers, etc? ____

Is your child generally healthy? Yes _____ No _____

Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes ____ No ____

If yes, please list ____

Has a Neurological evaluation ever been performed? Yes _____ No ______

By whom? ___________________________________ Results: _______________________________

NUTRITIONAL INFORMATION

Current Diet: Excellent ______ Good ______ Fair ______ Poor ______

Does your child: like sweets Yes _____ No _____ Crave Sweets Yes _____ No _____

Is your child active? Yes _____ No _____ Moderately? ______ Extremely? ______

Are there periods of: Very High Energy? Yes ___ No ___ Very Low Energy? Yes ___ No ___

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes ___ No ___ Normal Birth? Yes ___ No ___

Any complications before, during or immediately following delivery? Yes ____ No ____

Did your child creep (stomach on floor) Yes ___ No ___ Age __________

Did your child crawl (stomach on floor) Yes ___ No ___ Age __________

All Fours? Yes ___ No ____ If not, describe: __________________________________

At what age did your child walk? ________ Was your child active? Yes ___ No ___

Speech: First words at age? ______ Was early speech clear to others: Yes ___ No ___

Is speech clear now? Yes ___ No ___

VISUAL HISTORY

Doctor's Name ________________________________ Date of lat visit ________________

Reason for examination ____

Results ____

Were glasses prescribed? Yes ____ No ___ Are they worn? Yes ___ No ___

If yes, when are they worn? ____

Members of the family who have visual problems and the reasons:

Name Age Visual Situation ____________________________

____

____

PRESENT SITUATION

Is there any evidence from school or psychological tests that indicate some visual malfunction may be present Yes _____ No _____ If yes, what? ____

____

TELEVISION VIEWING

How much? __________ How often? __________ Viewing Distance ___________

SCHOOL

Age at time of entrance to: Kindergarten _________________
First Grade __________________

Does your child like school? Yes _____ No _____

Has your child changed schools often? Yes _____ No _____
If yes, When? ___________________________________
Has a grade been repeated? Yes _____ No _____
If yes, Which? ___________________________________

Does your child seem to be under tension or extreme pressure when doing school work?
Yes _____ No _____

Has your child had any special tutoring or received special services from an OT, PT or Speech Pathologist?

If yes, when? ____

From whom? ____

Where? ____

How long? ____

Results? ____

What school subjects are easy for child? ____

What school subjects are difficult for child? ____

Does your child like to read? Yes ___ No ___ Voluntary? Yes ___ No ___

What does he/she like to read? ____

Specifically describe any school difficulties: ____

____

What is your child's attitude toward reading, school, his/her teachers, other youngsters? __________

____

____

School work is: Above Average _____ Average _____ Below Average _____

Do you feel your child is achieving up to potential? Yes _____ No _____

Does the teacher feel your child is achieving up to potential? Yes _____ No _____

GENERAL BEHAVIOR

Are there any behavior problems at school? Yes_____ No _____

Are there any behavior problems at home? Yes _____ No _____

What causes these problems? ____

Child's reaction to fatigue? Sag ____ Irritable _____ Other ______________________

Child's reaction to tension? Nail-biting _____ Thumb sucking _____ Other ____________

Does your child say and/or do things impulsively? Yes _____ No _____

Is your child in constant motion? Yes _____ No _____

Can your child sit still for long periods? Yes _____ No _____

FAMILY AND HOME

Please indicate which adult he/she lives with? Mother _____ Father _____ Other ____________

Hs your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? Yes _____ No _____

What age was he/she? _______ Does your child seem to have adjusted? Yes _____ No _____

Is family life stable at this time? Yes_____ No _____

How does the child get along with?
Parents? ____

Siblings? ____

Classmates in school? ____

Playmates at home? ____

Did father or anyone in father's family have a learning problem? Yes _____ No _____
Who? ____

Did mother or anyone in mother's family have a learning problem? Yes _____ No _____

Do any, or did any, of the other children in the family have learning problems? Yes ____ No ____
Who? ____

To what extent? ____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

RELEASE OF INFORMATION AND INSURANCE

I agree to permit information from, or copies of, my child's examination records to be forwarded to other health care providers or insurance carriers upon written request or upon the recommendation of Charles Shidlofsky, O.D. when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims.

____ _________________________
Signature Date