EAGLE VISION & EYE CLINIC, PC

Doctors of Optometry
CLARK B. BLACKWOOD, OD
LARRY L. FORREST, OD
JACLYN M. WRAY, OD
RACHEL A. POTTER, OD
GINA M. GABRIEL, OD, MS
Certified, American Board of Optometry

Ages 0 to 5 year 11mo Child History Form

Child's Name: _____ Date_____ DOB:___ /___ /___

Parent (s) or Guardian (s): _____

What brought you in today? _____

EYE HISTORY

Have you ever noticed any of the following happening? (please check any that apply)

Eye turn: ☐ in ☐ out ☐ Eyes watering ☐ Eyes red ☐ Swelling around the eyes
☐ White appearance in pupil ☐ Difficulty seeing

Explain any eye concerns noted by observing the child: _____

_____

PREGNANCY/DELIVERY

Length of pregnancy: _____ weeks List any complications during pregnancy: _____

Parent's ages at time of birth: Mother _____ Father _____ Birth Weight _____

List any complications during delivery: _____
Was oxygen used? ☐ no ☐ yes

List any complications of development: _____

List any accidents, eye, or head injuries, and age they occurred: _____

Has your child had any of the following: ☐ Speech therapy ☐ Occupational therapy ☐ Physical therapy ☐ Vision Therapy ☐ Other: _____

2080 N. MAIN STREET • LONGMONT, COLORADO 80501-1916
PHONE 303-651-2020 • FAX 303 776-2460 • EMAIL: info@evec.com
www.evec.com