CENTRAL ILLINOIS EYECARE, L.L.C.

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Child's Expanded History Questionnaire (Pre---K and Under)

(Please fill out all that apply to your child's age)

Patient's Name _____ Date:_____

Date of Birth:_____ Name of Parent or Guardian:_____

Primary Care Doctor: _____

Has your child been diagnosed with or suspected of having any of the following conditions? (If yes, check the appropriate box)

Allergies	❑	Head Trauma	❑	Epilepsy or Seizures	❑
Developmental Disorder	❑	Asthma	❑	Hyperactivity	❑
Pre---Mature Birth	❑	Trauma at Birth	❑	Frequent Ear Infections	❑

Please circle Yes or No for any of the following behaviors that have been noticed:

Eye Turn	Yes	No	Swelling Around Eyes	Yes	No
Squinting	Yes	No	Frowning or Blinking	Yes	No
Rubs Eyes	Yes	No	Red Eyes	Yes	No
Covers one eye	Yes	No	Abnormal Head Posture	Yes	No
Short attention span	Yes	No	Close working distance	Yes	No
Lack of concentration	Yes	No	Watery Eyes	Yes	No
Frequent Headaches	Yes	No	Difficulty catching a ball	Yes	No

Has your child received special testing? **Yes** **No**

Has your child had any previous vision care? **Yes** **No**

Please describe any difficulty your child had in learning motor skills (walking, skipping) or language skills:

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