OFFICE USE ONLY
☐ RTC VIP
☐ TVPS ☐ GARDNER
☐ BEERY ☐ WOLD

OFFICE USE ONLY:
RET PHOTO TAKEN ☐
TAKE RET PHOTO WHEN DILATED ☐
NO RETINAL PHOTO ☐
SCANNED ☐

EXAMINATION INTAKE FORM – CHILD

PLEASE PRINT CLEARLY

CHILD'S FULL NAME:	BIRTH DATE (DD/MM/YY):	MALE ☐ FEMALE ☐
HOME ADDRESS:	HEALTH CARD #:	
CITY:	PARENT'S NAMES:	
POSTAL CODE:	CELL PHONE #:	
HOME PHONE #:	ALTERNATE #:	
EMAIL ADDRESS:		
☐ **I GIVE** VAUGHAN FAMILY VISION CARE PERMISSION TO EMAIL ME WITH MEDICAL REPORTS, EDUCATION & PERSONAL COMMUNICATIONS ☐ **I DO NOT GIVE** VAUGHAN FAMILY VISION CARE PERMISSION TO EMAIL ME WITH MEDICAL REPORTS, EDUCATION & PERSONAL COMMUNICATIONS		
SIGNATURE OF CONSENT:	DATE OF CONSENT:	
HOW WERE YOU REFERRED TO US?	REASON FOR REFERRAL:	

HEALTH HISTORY

FAMILY DOCTOR:	DATE OF LAST EYE EXAM:
ALLERGIES (please specify):	HOSPITALIZATIONS:
MEDICATIONS:	REASONS FOR MEDICATIONS:

ANY HISTORY OF: (IF A FAMILY MEMBER HAS ANY MEDICAL HISTORY, **PLEASE INDICATE WHO [grandmother, father, etc])**

☐ **SELF** ☐ **FAMILY** ENVIRONMENTAL ALLERGIES	☐ **SELF** ☐ **FAMILY** HIGH BLOOD PRESSURE
☐ **SELF** ☐ **FAMILY** HEART DISEASE	☐ **SELF** ☐ **FAMILY** CATARACTS
☐ **SELF** ☐ **FAMILY** ARTHRITIS	☐ **SELF** ☐ **FAMILY** GLAUCOMA
☐ **SELF** ☐ **FAMILY** HIGH CHOLESTEROL	☐ **SELF** ☐ **FAMILY** STROKE
☐ **SELF** ☐ **FAMILY** MACULAR DEGENERATION	☐ **SELF** ☐ **FAMILY** RETINAL DETACHMENT
☐ **SELF** ☐ **FAMILY** EYE INJURY	☐ **SELF** ☐ **FAMILY** TUBERCULOSIS
☐ **SELF** ☐ **FAMILY** DIABETES	☐ **SELF** ☐ **FAMILY** HIV/ HEPATITIS
☐ **SELF** ☐ **FAMILY** EYE SURGERY	☐ **SELF** ☐ **FAMILY** NEUROMUSCULAR

VISUAL HISTORY & EYE HEALTH

☐ BLURRED DISTANCE VISION / SQUINTING	☐ UNCOMFORTABLE CONTACT LENSES
☐ BLURRED INTERMEDIATE VISION	☐ AMBLYOPIA (LAZY EYE)
☐ BLURRED CLOSE VISION	☐ DROOPING EYELID
☐ SUDDEN VISION LOSS	☐ FLUCTUATING VISION
☐ DOUBLE VISION	☐ GLARE/ LIGHT SENSITIVITY
☐ FLOATING SPOTS	☐ MUCUS DISCHARGE
☐ RED EYES	☐ STRABISMUS
☐ WATERY EYES/ BURNING EYES	☐ CORNEAL TRANSPLANT
☐ FREQUENT HEADACHES	☐ EYE TURN
☐ FLASHES OF LIGHT	☐ KERATOCONUS
☐ DRY EYES	☐ OTHER:

HISTORY OF CONCUSSION: ☐ **YES** ☐ **NO**	DATE OF LAST CONCUSSION (MM/DD/YY):
PARTICIPANT OF COMPETITIVE SPORT : ☐ **YES** ☐ **NO**	**SEE BACK ->**

VISUAL HISTORY

Any learning-related diagnosis? ☐ **YES** ☐ **NO** IF SO, PLEASE LIST:

Please describe any previous eye or visual problems and treatment your child has received (including glasses, vision therapy, patching, surgery, medications, etc…):

EDUCATIONAL HISTORY

CURRENT SCHOOL:	GRADE:

HAS YOUR CHILD REPEATED ANY GRADES? ☐ **YES** ☐ **NO** IF YES, WHICH ONES?

IS YOUR CHILD RECEIVING ANY TUTORING, EXTRA HELP OR SPECIAL CLASSES? ☐ **YES** ☐ **NO** IF YES, PLEASE DESCRIBE:

ACADEMIC COMPLAINTS

- ☐ LOSS OF PLACE WHILE READING/ SKIPPING WORDS & LINES
- ☐ POOR HANDWRITING
- ☐ HOLDS BOOK TOO CLOSE
- ☐ POOR SPELLING
- ☐ POOR, INEFFICIENT READING
- ☐ MATH DIFFICULTY: FACTS/ CONCEPTS
- ☐ WORDS MOVING OR RUNNING TOGETHER
- ☐ DIFFICULTY COPYING FROM THE BOARD
- ☐ POOR READING COMPREHENSION
- ☐ AVOIDS READING
- ☐ FREQUENT LETTER, NUMBER OR WORD REVERSALS

CURRENT ACADEMIC LEVELS (PLEASE CHECK APPROPRIATE BOX)

	ABOVE GRADE	ON GRADE	BELOW GRADE	SPECIAL HELP
READING	☐	☐	☐	☐
READING COMPREHENSION	☐	☐	☐	☐
SPELLING	☐	☐	☐	☐
MATH	☐	☐	☐	☐
HANDWRITING	☐	☐	☐	☐

DEVELOPMENTAL HISTORY

WERE THERE ANY COMPLICATIONS WITH PREGNANCY OR DURING BIRTH? ☐ **YES** ☐ **NO** IF YES, PLEASE DESCRIBE:

WAS YOUR CHILD BORN PREMATURELY? ☐ **YES** ☐ **NO** IF YES, HOW SOON?

CHILD'S BIRTH WEIGHT:	APGAR SCORE:

WHEN DID YOUR CHILD BEGIN WALKING UNASSISTED?

WHEN DID YOUR CHILD BEGIN TO CRAWL?

WHEN DID YOUR CHILD BEGIN TO SPEAK 2-3 WORD PHRASES?

IS YOUR CHILD CLUMSY? ☐ **YES** ☐ **NO**	ANY SPEECH PROBLEMS NOW OR IN THE PAST? ☐ **YES** ☐ **NO**

ANY PROBLEMS WITH FINE MOTOR CO-ORDINATION? ☐ **YES** ☐ **NO**

DOES YOUR CHILD ENJOY, AND PARTICIPATE IN ACTIVITIES SUCH AS DRAWING, COLOURING, PUZZLES, BLOCK PLAY, ETC?
☐ **YES** ☐ **NO** (WITH OLDER CHILDREN, DID THEY PREVIOUSLY?) ☐ **YES** ☐ **NO**

OTHER NECESSARY INFORMATION, PLEASE INDICATE:

SUBMIT