Dr. Marsha D. Benshir
Center for Vision Development
Optometrist
Member
American Optometric Association

Health and Developmental History

Child's Name_____ Birthdate_____ Grade_____
Parent's Names_____ Address_____
Telephone (Home)_____ (Parent's email)_____

Prenatal History (During mother's pregnancy with this child):
Any unusual health or medical problems (Rh neg., measles, viral infection, toxemia, pre-eclampsia, etc.)

_____
Any falls or other accidents _____
Any use of prescription or non-prescription drugs _____
Any use of alcohol or illegal drugs_____

Birth History:
Any difficulties with the delivery (Anoxia, breach birth, etc) _____

_____
Describe length of labor, help given to mother in form of drugs, or use of instruments

_____
Child's condition at birth (incubator, jaundiced, breathing problems, etc)_____

_____
Birth weight _____ Full term or premature _____
Any special medical attention or hospitalization required during first month? (i.e. oxygen, medication, etc.)

_____

Developmental History:
At what age did your child do the following: Sat alone_____ Crawled_____ Walked_____
Spoke first word_____ Said sentences (combined two or more words) _____ Toilet trained_____
Rode tricycle_____ Bicycle_____ Started swimming_____ Throw and catch ball_____
Learned numbers_____ Letters_____ Colors_____
Any activities or milestones accelerated or delayed (please list):_____

_____
Right or left handed?_____ At what age was this noted?_____ Any Concerns?_____

Center for Vision Development ● 164 W. Main Street, Suite B ● New Market, Maryland 21774
Office 301-829-1910 ● Fax 301-865-1973 ● www.optometrists.org/cvd

How would you describe your child's temperament (happy, irritable, withdrawn, fears, etc.)_____
Any bed wetting or soiling (How often?) _____
Any feeding problems:_____
Any concerns about speech:_____
Any concerns about motor coordination:_____
Age child entered preschool, if any _____ Any difficulties noted? _____
Age child entered school _____ Any difficulties noted?_____
Special services provided (Remedial Reading/Chapter 1/Special Education/Speech) Please be specific

_____
Was child retained, what grade _____
Has child received any psychological evaluations or counseling through school or private sources?_____

_____

Health History:

Does child have a history of any of the following conditions: Respiratory_____ Cardiovascular _____
Gastrointestinal_____ Musculoskeletal _____ Neurological _____ Allergies_____
Hearing (ear infections)_____ Vision_____ Other_____
Note any serious illness, surgery or unusual conditions _____

_____
If high fever accompanied illness, mention degree and duration: _____
_____ Any convulsions?_____
Note any accidents or head injuries: _____
Was child ever unconscious?_____ How long?_____
Has child ever been referred to a specialist or been seen by an outside clinic?_____

_____
If so, please specify date and results:_____

_____

Present Health:

Does child have any of the following symptoms more frequently than most children (check all that apply):
Indigestion___ Constipation___ Diarrhea___ Vomiting___ Fever___ Fatigue___ Dizzy spells___
Restlessness___ Inattention___ Headaches___ (when and how often)_____
Staring spells___ Aches and pains___ Difficulty sleeping___ Difficulty eating/picky eater_____
Other health conditions or diagnoses_____
Any medications (Please note dosage) _____
Date of last physical examination_____ Physician's Name_____

Family History:

Please check any family history of these conditions among parents, siblings, grandparents, etc.:
Vision problems___ Hearing problems___ Speech problems___ Reading problems___
Learning disabilities___ Special Education___ Attention problems___ Hyperactivity___
Seizure disorders___ Legal problems___ Emotional problems (depression, anxiety, etc.) ___
Left-handedness___ Alcohol/Drug abuse___ Behavior problems___
Present health of family members_____

Environment:

If both parents work outside of the home, who is caretaker:_____

How many hours per day is child with caretaker:_____

Is a second language spoken in the home?_____ language: _____

Child's relationship with family members:_____

_____

Child's relationships with friends, neighbors:_____

Activities or types of play in which the child participates (Sports, clubs, etc.):_____

_____

Any recent family stressors?_____

_____

Has child experienced any prenatal separations, divorces, or death, and if so, is this ongoing?

_____

Are there custody and visitation considerations?_____

_____

Any other history of significant losses or separations?_____

_____

Any history of abuse or neglect?_____

_____

How does child handle self-care and responsibilities in the home?_____

_____

How much time does your child spend watching television, videos, or playing video games?_____

_____

Does anyone in the home smoke?_____ Any pets?_____

Date completed_____ Name of person completing form_____

Signature_____

Thank you for completing this form. Please list any additional considerations or concerns:_____

_____

_____

_____

_____

_____

_____

_____

(Please use the back of this form for any additional information that does not fit in the space provided.)