Dr. Taylor & Associates

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Age: _____ Today's Date: _____
Birth Date: _____ SSN: _____ Last Eye Exam: _____
Address: _____ Last Eye Doctor: _____
City: _____ St: _____ Zip: _____ Last Medical Exam: _____
Phone Number: (h) _____ (w) _____ Current Medical Dr.: _____
E-mail: _____

Vision Insurance Plan: _____ Name of Insured: _____
Member ID Number: _____ Employer: _____
Spouse: _____ Referred by: _____

Reason for visit: _____

Medical History

Do you have any allergies to medications? ❑ Yes ❑ No If yes, explain: _____
_____
List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____
_____
_____
List all major injuries, surgeries and/or hospitalizations you have had: _____
_____

Are you pregnant and/or nursing? ❑ Yes ❑ No If yes, explain: _____
Have you had any eye surgeries? ❑ Yes ❑ No If yes, explain: _____
Have you ever had vision therapy? ❑ Yes ❑ No If yes, explain: _____
Have you ever injured your eyes? ❑ Yes ❑ No If yes, explain: _____
Do you wear glasses? ❑ Yes ❑ No If yes, how old is your present pair of lenses? _____
Do you wear contact lenses? ❑ Yes ❑ No If yes, how old is your present pair or lenses? _____
Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other _____
Name of lenses: _____ Are they comfortable? _____

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

Visual System	current	past	never
Loss of Vision	❑	❑	❑
Blurred Vision	❑	❑	❑
Double Vision	❑	❑	❑
Halos	❑	❑	❑
Dryness	❑	❑	❑
Redness	❑	❑	❑
Itching	❑	❑	❑
Burning	❑	❑	❑
Excess Tearing	❑	❑	❑
Light Sensitive	❑	❑	❑
Eye Pain	❑	❑	❑
Eye Infections	❑	❑	❑
Floaters	❑	❑	❑
Flashes	❑	❑	❑
Tired Eyes	❑	❑	❑
Crossed Eyes	❑	❑	❑
Cataracts	❑	❑	❑
Glaucoma	❑	❑	❑
Retinal Disease	❑	❑	❑

Systemic System	current	past	never
Diabetes	❑	❑	❑
Heart Disease	❑	❑	❑
High Blood Pressure	❑	❑	❑
Urogenital (kidney, bladder)	❑	❑	❑
Rheumatoid Arthritis	❑	❑	❑
Blood (Anemia, cholesterol)	❑	❑	❑
Fever	❑	❑	❑
Weight Loss/Gain	❑	❑	❑
Allergies/Hay Fever	❑	❑	❑
Gastrointestinal	❑	❑	❑
Endocrine (thyroid, etc.)	❑	❑	❑
Neurological (MS, seizures)	❑	❑	❑
Skin (acne, cancer)	❑	❑	❑
Psychiatric (depression, etc.)	❑	❑	❑
Headaches/Migraines	❑	❑	❑
Respiratory (asthma, bronchitis, emphysema)	❑	❑	❑
Other: _____	❑	❑	❑

Please fill out the back side...

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❑Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? ❑ Yes ❑ No If yes, do you have visual difficulty when driving? ❑ Yes ❑ No
If yes, please describe: _____
Do you use tobacco products? ❑ Yes ❑ No If yes, type/amount/how long: _____
Do you drink alcohol? ❑ Yes ❑ No If yes, type/amount/how long: _____
Do you use illegal drugs? ❑ Yes ❑ No If yes, type/amount/how long: _____
Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis ❑ None

What type of work do you do? _____
Do you go to school? ❑ Yes ❑ No If yes, where and grade level/field of study? _____
Do you play any sports? ❑ Yes ❑ No If yes, type and amount: _____
Other forms of exercise? _____
Do you have any hobbies? _____
How many hours per day do you:
Work on a computer? _____
Read? _____
Watch TV? _____
Play video games? _____

Family History

Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease/Condition	**Yes**	**No**	**Not Sure**	**Relationship to you**
Blindness	❑	❑	❑	_____
Cataract	❑	❑	❑	_____
Crossed Eyes	❑	❑	❑	_____
Glaucoma	❑	❑	❑	_____
Macular Degeneration	❑	❑	❑	_____
Retinal Detachment/Disease	❑	❑	❑	_____
Systemic Disease/Condition				
Arthritis	❑	❑	❑	_____
Cancer	❑	❑	❑	_____
Diabetes	❑	❑	❑	_____
Heart Disease	❑	❑	❑	_____
High Blood Pressure	❑	❑	❑	_____
Kidney Disease	❑	❑	❑	_____
Lupus	❑	❑	❑	_____
Thyroid Disease	❑	❑	❑	_____
Other _____				_____

Our goal is to provide the best, most complete, up-to-date care available. Our philosophy is preventive and developmental in approach. To provide this service in the most efficient manner, please be aware of the following office policies:

- ❑ *Fees for services are due at the time those services are rendered.*
- ❑ *A deposit is required on all materials and balance due upon delivery.*
- ❑ *We reserve the right to charge for missed appointments not cancelled in advance.*
- ❑ *Visual training patients must notify us of absences in advance.*
- ❑ *There is a charge for written reports.*
- ❑ *Responsibility for payment is the patient's. Insurance agreements are between company and patient. We will assist with proper forms but require reimbursement from patients.*

Signature: _____ *Date:* _____

Dr. Taylor & Associates
5012 Dorsey Hall Drive
Suite 105
Ellicott City, MD 21042

410-730-8878
410-997-8272(fax)
www.taylorvisionandlearning.com

Developmental Questionnaire

Child's Name _____Sex _____Age____ DOB:_____ Date:_____
Father's Name_____ Phone: _____(h)_____(w)
Mother's Name _____Phone_____(h)_____(w)
Home Address_____

Reason for Referral _____
Referred by_____
What do you want to find out from the exam?_____

Family
1. Father: occupation _____marital status_____ grade completed_____
2. Mother: occupation _____ marital status _____ grade completed _____
3. Languages spoken in home _____
4. Siblings (age and sex) _____

Developmental History
1. Is the child adopted? _____ If yes, does the child know? _____ Age when adopted? _____
2. Was pregnancy full term? _____ _____ Child's weight at birth _____
3. Complications before, during, following delivery? _____
4. Was child exposed to: ____ drugs in utero _____alcohol _____nicotine
5. At what time did the following occur:
   creeping (stomach off floor) _____ crawling (stomach on floor) _____ sitting alone_____
   walking alone _____ feeding self_____ voluntary bladder control _____
   tendency to show handedness _____
6. Has anyone attempted to change child's handedness?___

Medical History
1. Has your child had any serious accidents, operations or unusual illnesses? If so, please specify.
   _____
   _____
   _____
2. List any allergies _____
3. Medications/vitamins currently being used: _____
4. Last medical exam _____
   What were the recommendations? _____
   Name of Pediatrician _____
   Does test taking appear to cause anxiety? _____
6. Has your child or family been referred for counseling? _____
   If so, what was the reason for referral_____
   Was the therapy successful? _____

Vision Care
Last eye exam _____ Location/ Doctor _____
Does your child currently wear eyeglasses? _____ If yes, how old are they?_____
Has your child been treated with a patch or eye drops for Amblyopia? _____
If yes, describe the treatment plan _____

Has your child reported any of the following:

- ❑ Headaches If yes, when _____
- ❑ Blurred vision _____
- ❑ Tired eyes _____
- ❑ Double vision _____
- ❑ Light sensitivity _____

Have you noticed any of the following while observing your child?

- ❑ Squinting
- ❑ Close/cover one eye
- ❑ Eye rubbing
- ❑ Excessive blinking
- ❑ Reverses words/letters
- ❑ Skips words or rereads
- ❑ Moves lips while reading quietly
- ❑ Moves head while reading
- ❑ Tilts head while reading
- □ Loses place when reading
- □ Writes or prints poorly
- □ Difficulty copying from blackboard
- □ Tires when reading/doing homework
- □ Eye turning inward/outward
  If so, one eye or both, distance or near
- □ Hold his/her book too close while reading

General Development Skills

1. At what age did your child:
   Speak first sentence_____ Ask first questions _____
2. Was there another method of communication prior to speech?_____
3. Does your child have a speech or language deficit? _____
4. Has your child had speech therapy? _____
5. Has your child had physical therapy? _____ Occupational therapy? _____
   Was therapy succesful?_____

General Health

1. Does your child sleep through the night? _____
2. Current hours of sleep per night? _____
3. Does your child have a good diet? _____
4. Does your child eat fruit and vegetables? _____
5. Does your child take vitamin supplements? _____
6. Is there a high desire for sweets or junk food? _____
7. Are there any food allergies? _____ If yes, please list _____
8. Is you child on a restricted diet? _____ If yes, please explain _____

Family and Home

1. What responsibilities does your child have at home? _____
   _____
2. Can your child carry out these responsibilities independently? _____
3. Describe special interests/hobbies: _____
4. State any tensional behavior such as nail biting, eye blinking, excessive eye rubbing, tantrums or tongue chewing _____
5. What discipline is most effective in guiding your child? _____
   _____
6. What adults besides the parents plan an active part in guiding your child?
   _____

School Information

Please list the schools your child has attended, beginning with the current school (including home school)

Name	Location	Grade Level
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

1. Does your child like school? _____ Is their attendance regular? _____
2. Has your child ever been retained? _____ If yes, what grade? _____
   How did your child react to retention? _____
3. What is the structure of the school (traditional, open classroom, etc)_____
4. Which subject does your child enjoy the most? _____
5. How do you think your child performs in the following areas:

Reading comprehension	very good	adequate	fair	inadequate	poor
Sight vocabulary	very good	adequate	fair	inadequate	poor
Reading speed	very good	adequate	fair	inadequate	poor
Spelling	very good	adequate	fair	inadequate	poor
Handwriting	very good	adequate	fair	inadequate	poor
Expressing thoughts verbally	very good	adequate	fair	inadequate	poor
Expressing thoughts through writing	very good	adequate	fair	inadequate	poor
Math concepts	very good	adequate	fair	inadequate	poor
Attention span	very good	adequate	fair	inadequate	poor
Ability to follow written directions	very good	adequate	fair	inadequate	poor
Ability to follow verbal directions	very good	adequate	fair	inadequate	poor

6. Does your child memorize answers or does she/he think through a problem to obtain the solution?
_____
7. What is your child's general attitude towards present school teachers? _____
8. What is your child's attitude towards teachers in general? _____
9. Type of teacher to whom your child is most responsive (i.e. make, female, strict, flexible):
_____
10. How would you rate your child's popularity among his/her classmates (ignored, rejected, accepted):
_____
11. Does the school consider your child to have a learning problem? _____ Discuss:
_____
12. Does the school consider your child to have a discipline problem? _____
    If yes, please describe:_____
13. Has your child had any previous testing done at the school level? _____
    If yes, please describe: _____
14. Does your child like to read? _____ If yes, what types of materials? _____
15. Does your child read as well as expected? _____

General Movement

1. Is your child physically active? _____
2. List team sports: _____
3. List individual sports: _____
4. Can your child catch a ball? _____ Throw a ball? _____
5. Would you consider your child to have good rhythm? _____
   Is your child clumsy? _____ Is your child coordinated? _____
6. Does you child avoid sports? _____

Behavioral Characteristics

The following is a list of characteristics that can often be observed in children. Please circle the appropriate response as they apply to your child.

Cries	most often	sometimes	rarely	unknown
Daydreams	most often	sometimes	rarely	unknown
Is friendly	most often	sometimes	rarely	unknown
Gets in fights	most often	sometimes	rarely	unknown
Is happy, light-hearted	most often	sometimes	rarely	unknown
Interacts well with adults	most often	sometimes	rarely	unknown
Has to be prodded to get things done	most often	sometimes	rarely	unknown
Follows through on tasks	most often	sometimes	rarely	unknown
Listens to reason	most often	sometimes	rarely	unknown
Nervous, irritable	most often	sometimes	rarely	unknown
Obeys	most often	sometimes	rarely	unknown
Is honest	most often	sometimes	rarely	unknown
Talks back	most often	sometimes	rarely	unknown
Temper tantrums	most often	sometimes	rarely	unknown
Timid, shy	most often	sometimes	rarely	unknown
Has strong fears	most often	sometimes	rarely	unknown
Becomes frustrated	most often	sometimes	rarely	unknown
Is dominated by other children	most often	sometimes	rarely	unknown
Takes lead with peers	most often	sometimes	rarely	unknown
Plays with children of same age	most often	sometimes	rarely	unknown
Plays with children of older age	most often	sometimes	rarely	unknown
Plays with children of younger age	most often	sometimes	rarely	unknown

Are any of the above behaviors significantly different at home vs. school?

_____

Please describe any other characteristics of your child that we should be aware of in order to meet his/her needs as fully as possible.

_____

_____

_____

❖ ***Did you answer all four pages? Thank you***

Signature _____

Relationship to child _____

Date _____