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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	<input type="checkbox"/>	Head Trauma	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>
Developmental Disorder	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>
Pre-Mature Birth	<input type="checkbox"/>	Trauma at Birth	<input type="checkbox"/>	Frequent Ear Infections	<input type="checkbox"/>

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:
