Student Medical History

Student Name: _____Date_____
Completed By: _____Relationship to student_____
Eye Surgery/Conditions_____
Medications: _____
Allergies_____

Check the column which best represents the occurrence of each symptom.	*Never 0*	*Seldom 1*	*Occasionally 2*	*Frequently 3*	*Always 4*
Blur when looking at near					
Double vision					
Headaches with near work					
Words run together reading					
Burning, itchy, watery eyes					
Falls asleep reading					
Sees worse at end of day					
Skips / repeats lines when reading					
Dizziness / nausea with near work					
Head tilt / closing one eye when reading					
Difficulty copying from chalkboard					
Avoids near work / reading					
Omits small words when reading					
Writes uphill / downhill					
Misaligns digits / columns of numbers					
Reading comprehension down					
Poor / inconsistent in sports					
Holds reading too close					
Trouble keeping attention on reading					
Difficulty completing assignments on time					
Always says “I can’t” before trying					
Avoids sports / games					
Poor hand / eye (poor handwriting)					
Does not judge distance accurately					
Clumsy, knocks things over					
Does not use his / her time well					
Does not make change well					
Loses belongings / things					
Car / motion sickness					
Forgetful / poor memory					

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