

INFANT/TODDLER VISION QUESTIONNAIRE

Please fill out this questionnaire carefully. Please return to our office prior to your appointment.

Appointment: Day _____ Date _____ Time _____

Patient's Name: _____

GENERAL INFORMATION

Were you referred? Yes ___ No ___

If yes, by whom? _____ Phone: _____

Address: _____

Child's Full Name: _____ Male ___ Female ___

Birth Date: _____ Age: _____ years _____ months

Delivery Due Date: _____

HOME	Father	_____	Birth Date	_____
	Mother	_____	Birth Date	_____
	Brothers	_____	Birth Date	_____
	And	_____	Birth Date	_____
	Sisters	_____	Birth Date	_____
		_____	Birth Date	_____

PARENT INFORMATION

Home Address _____ City _____ State _____ Zip _____

Home Phone _____

Father's Employer _____ Business Phone _____

Business Address _____ City _____ Zip _____

Mother's Employer _____ Business Phone _____

Business Address _____ City _____ Zip _____

Do you have Major Medical Insurance? _____ Policy # _____

If so, who is the carrier? _____

Name of insured _____

Social Security Number _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Results _____

Medications currently using (including over the counter) _____

For what condition? _____

Are you allergic to any medications? Yes ___ No ___

If yes, please list. _____

Birth Weight _____

Did the mother experience any health problems during the pregnancy, especially during the first trimester?

Yes ___ No ___ If yes, please explain: _____

(MEDICAL HISTORY – continued)

List illnesses, bad falls, high fevers, etc:

Age Severe Mild Complications

Is your child generally healthy? _____

Are there any chronic problems like ear infections, asthma, hay fever, allergies?Yes ___ No ___

If yes, please list _____

Has a neurological evaluation been performed? Yes ___ No ___

By whom? _____ Results _____

Has a psychological evaluation been performed? Yes ___ No ___

By whom? _____ Results _____

Is there any history of the following? (please check if there is a history)

Is there any history in your family of the following:

- Diabetes Yes ___ No ___
- Glaucoma Yes ___ No ___
- High Blood Pressure Yes ___ No ___
- Strabismus Yes ___ No ___
- Multiple Sclerosis Yes ___ No ___
- “Cross” or “Wall” eye Yes ___ No ___
- Chromosomal imbalance Yes ___ No ___
- Amblyopis (“lazy” eye) Yes ___ No ___
- Learning Disability Yes ___ No ___
- Other Yes ___ No ___

If other, please explain: _____

Have there been any previous surgeries, hospitalizations, or major injuries? Yes ___ No ___

If yes, please explain _____

DEVELOPMENTAL HISTORY

Full-term pregnancy Yes ___ No ___

Normal birth? Yes ___ No ___

Were forceps used? Yes ___ No ___

Any complications before, during, or immediately following delivery? Yes ___ No ___

Were there any difficulties at all in nursing (such as vomiting)? Yes ___ No ___

Was there every any reason for concern over your child’s general growth or development?

Yes ___ No ___ If yes, why? _____

Did your child crawl (stomach on floor)? Yes ___ No ___

At what age? _____

Did your child creep (stomach off floor)? Yes ___ No ___

At what age? _____

All fours? Yes ___ No ___

If not, describe _____

At what age did your child sit up (without support)? _____

At what age did your child walk (without support)? _____

Was your child active? Yes ___ No ___

If yes, was activity level low, moderate, or high? _____

Speech: First words at age _____

Was early speech clear to others? Yes ___ No ___

Is it clear now? Yes ___ No ___

NUTRITIONAL INFORMATION

Current Diet: Excellent _____ Good _____ Fair _____ Poor _____
Does your child: like sweets Yes ___ No ___
 crave sweets Yes ___ No ___
Is your child active? Yes ___ No ___
 moderately? Yes ___ No ___
 extremely? Yes ___ No ___
Are there periods of: very high energy? Yes ___ No ___
 very low energy? Yes ___ No ___

TELEVISION VIEWING

How much? _____ How often? _____ Viewing Distance _____

VISUAL HISTORY

Why do you feel your child needs a visual examination? _____

Was the child’s vision previously examined? Yes ___ No ___

Doctor’s Name _____ Date of Last Visit _____

Reason for examination: _____

Results _____

Was therapy recommended? _____

 If yes, what type of therapy (Vision Therapy, Patching, Surgery, Glasses, Contacts, etc.)? _____

Please list any members of the family who have had visual attention and the reason:

<u>Name</u>	<u>Age</u>	<u>Visual Situation</u>
_____	_____	_____
_____	_____	_____

Please list any members of the family who have had visual attention and the reason:

<u>Name</u>	<u>Age</u>	<u>Visual Situation</u>
_____	_____	_____
_____	_____	_____

Please check “yes” or “no” to the following observations and/or complaints as they relate to your child:

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Eyes turn in or out or do not appear straight especially when child is tired.	_____	_____	_____
Has reddened or encrusted eyelids	_____	_____	_____
Has frequent sties	_____	_____	_____
Eyes in constant motion	_____	_____	_____
Eyelid droop	_____	_____	_____
Stares at bright lights or repeatedly flick objects in front of face	_____	_____	_____
Is abnormally bothered by bright lights	_____	_____	_____
Has watery eye(s)	_____	_____	_____
Turns head to use one eye only	_____	_____	_____
Tilts head to one side	_____	_____	_____
Places an object close to eyes to look at it	_____	_____	_____
Squints while looking at objects	_____	_____	_____
Blinks excessively	_____	_____	_____
Has tendency to rub eyes	_____	_____	_____
Covers or closes one eye	_____	_____	_____
Stumbles over objects or is clumsy	_____	_____	_____
Lacks interest in looking at objects or seeing	_____	_____	_____
Unable to transfer object from hand to hand, crossing the middle of his/her body	_____	_____	_____
Is unable to stack blocks or other objects	_____	_____	_____

List any other complaints your child makes concerning his/her vision: _____

PRESCHOOL/DAY CARE

If your child attends preschool or daycare, please fill out the following:

Name of Preschool _____ Teacher _____ Director _____

Age at time of entrance to preschool/day care _____

Does your child like preschool/day care? Yes ___ No ___

Does your child like his/her teacher? Yes ___ No ___

Compared to other children his/her age, do his/her general performance and social skills seem to be:

Above ___ Equal to ___ or Below ___?

Which school activities are easy for your child? _____

What school activities are difficult for your child? _____

Specifically describe any school/day care difficulties: _____

Does your child seem to be under tension at preschool/day care? Yes ___ No ___

Has your child had any special developmental assistance? Yes ___ No ___

If yes, from whom? _____ Date of visit _____

Location _____ For how long? _____

Reason _____

Results _____

How well developed is your child's spoken vocabulary? _____

BEHAVIOR

Do you have any concerns about your child's behavior? Yes ___ No ___

If Yes, what are they? _____

Check the appropriate spaces if you have any concerns about the following behavior(s) in your child:

- | | |
|--------------------------|--|
| _____ lack of curiosity | _____ irritable, easily upset |
| _____ thumb-sucking | _____ restlessness |
| _____ nervous | _____ has difficulty separating from parents |
| _____ glum, sulky, moody | _____ sleeplessness |
| _____ bad temper | |

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

