INFANT/TODDLER VISION QUESTIONNAIRE

Please fill out this questionnaire carefully.

Child's Full Name____ Today's Date _______________
Date of Birth:__________________________________ Age ______ years ______ months
Gender: □ Male □ Female

RESPONSIBLE PERSON INFORMATION

Name: ____ Relationship ____________________________
Home Address:______________________________________ City/State ___________________ Zip__________
Preferred Phone: ______________________________________ □ Home □ Cell □ Work
Email: ____

MEDICAL HISTORY

Pediatrician's Name:_________________________________
Date of Last Evaluation: _______________
Office Address _______________________________________ City/ State __________________Zip____________
Medications currently using, including vitamins and supplements:
____
____

For what condition(s)? ____
Immunizations child has received and dates:

Immunization type: Date:
Immunization type: Date:
Immunization type: Date:
Immunization type: Date:
Any reactions to immunization(s)? Yes □ No □ If yes, explain:
____

List illnesses, bad falls, high fevers, etc.:

<u>Age</u> <u>Condition</u> <u>Complications</u>

____
____
____
____

Is your child generally healthy? Yes □ No □ If no, explain: ____
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 and recommendations: _______________________

Has a psychological evaluation been performed? Yes □ No □
By whom?____________________________________
Results and recommendations: _______________________

Has an occupational therapy evaluation been performed? Yes □ No □
By whom?____________________________________ Results and recommendations: _______________________

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

	Patient	Family	Who		Patient	Family	Who
Diabetes	□	□		High Blood Pressure	□	□	
"Cross" or "Wall" eye	□	□		Learning disability	□	□	
Chromosomal imbalance	□	□		Amblyopia (lazy eye)	□	□	
Glaucoma	□	□		Multiple Sclerosis	□	□	
Other	□	□		Epilepsy or seizures	□	□	

If other, please explain: ____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes □ No □

Did the mother experience any health problems during the pregnancy? Yes □ No □

If yes, explain: ____

Normal birth? Yes □ No □ Birth Weight ____________________

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

If yes, explain: ____

Was there ever any reason for concern over your child's general growth or development? Yes □ No □

If yes, why?____

Has your child received any special developmental guidance/ assistance? Yes □ No □

If yes, explain: ____

VISUAL HISTORY

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

Has your child had a previous eye examination ? Yes □ No □

If yes, Doctor's name ____________________________ Date of last exam ______________

Reason for examination ____________________Results and recommendations ____________________

Were glasses, contacts, or other optical devices recommended? Yes □ No □ If yes, what? ________________

Are they being used? Yes □ No □ If not used, why not?

____

Was surgery, therapy, or other treatments recommended? Yes □ No □

If yes, what? ____

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

	Yes	No	If yes, when?
An eye turns in or out	□	□	
Reddened or encrusted eyelids	□	□	
Frequent styes	□	□	
Eyes in constant motion	□	□	
Eyelids droop	□	□	
Is abnormally bothered by bright light	□	□	
Seems visually unaware	□	□	
Has watery eyes	□	□	
Turns head to use one eye only	□	□	
Tilts head to one side	□	□	
Moves objects very close	□	□	
Squints while looking at objects	□	□	
Blinks excessively	□	□	
Has a tendency to rub eyes	□	□	
Covers or closes one eye	□	□	
Stumbles over objects or is clumsy	□	□	
Poor motor control	□	□	
Poor attention when seeing near objects	□	□	
Unable to see distant objects	□	□	
Unable to transfer objects between hands			

or cross the midline of the body	◻	◻
Poor depth perception	◻	◻