

Welcome to our practice! Appointment Day: _____ Date: _____ Time: _____
A thorough history helps us to best administer testing and treatment to meet your child's visual needs.
Please print and fill this form out as completely as possible.

INFANT/PRESCHOOL QUESTIONNAIRE

Child's Name: _____ Birthdate: _____ Nickname: _____
Address: _____ Zip Code: _____
Home Telephone: _____
Mother's First and Last Name: _____ Occupation: _____
Email: _____ Work phone: _____ Cell phone: _____
Father's First and Last Name: _____ Occupation: _____
Email: _____ Work phone: _____ Cell phone: _____
Please list other family members at home (include ages and relationships): _____
Insurance Company: _____ Policy #: _____ Referred by: _____

VISION HISTORY:

In what ways does your child seem to have visual difficulties? _____

How long has the difficulty been noted? _____
Have you ever seen your child's eyes turn in or out? Yes ___ No ___ If yes, when? _____

Have you ever been told your child has a lazy eye? Yes ___ No ___ By whom? _____
Has your child had a previous visual examination? Yes ___ No ___ If so, by whom, when, and what was the
outcome? _____
Was glasses, surgery or therapy recommended? _____
Does anyone in your family have a lazy eye or a turned eye or other visual
condition? _____
Does your baby exhibit any of the following? Please check all that apply.
an eye turn in or out _____ frequent sties _____
frequently rubs the eyes _____ red, watery eyes _____
closes or covers one eye _____ blinks or squints excessively _____
turns or tilts head _____ places objects close to eyes _____
stumbles over objects _____ stares at bright lights _____
lacks interest in looking at things _____ unable to see distant objects _____
distractible or inattentive _____ appears to look through objects _____
has difficulty making eye contact _____ avoids near tasks _____
bothered by lights _____ tires easily _____
fearful of transitions on flooring _____ difficulty climbing _____
looks at things out of the sides of the eyes _____
repeatedly flicks objects in front of face _____
toe walks or exhibits other disturbances in gait or balance _____

DEVELOPMENTAL HISTORY:

Term of pregnancy _____ Weight at birth _____ APGAR Score: _____
Were there any complications before, during or immediately following delivery? Yes ___ No ___ If yes,
describe _____
Please describe the type of birth and any anesthetic used during the birth: _____

Did the mother take any medications during pregnancy? Yes ___ No ___ If yes, name of medication and
number of months pregnant at the time _____
Did the child have any difficulties in feeding? Yes ___ No ___ If yes, describe _____
Does your child sleep through the night? Yes ___ No ___
Does or did your child crawl? Yes ___ No ___ On all fours _____ At what age _____
At what age did your child: _____

show responsive smile _____ roll over _____
sit alone _____ walk alone _____

What things can your child do very well? _____

What things, if any, are difficult for your child? _____

Do you have any concerns regarding your child's social or cognitive development?

NUTRITIONAL INFORMATION:

Was your child breast or bottle-fed? _____ If bottle-fed, did or do you alternate feeding sides?

Does or did your child have colic or any allergies or sensitivities to formula? _____

Have solid foods been introduced? Yes ___ No ___ At what age? _____ If so, were there any reactions or allergies to any food(s)? _____

Activity Level: High ___ Moderate ___ Low ___

Are there periods of very high energy? Yes ___ No ___ low energy? Yes ___ No ___

Does your child crave sweets? Yes ___ No ___

What are his/her favorite foods? _____

What are his/her disliked/avoided foods? _____

SPEECH/LANGUAGE:

Age when spoke first words? _____ Sentences? _____

Was speech clear to others? Yes ___ No ___ Does your child seem to understand what is said to him/her?

Yes ___ No ___ Is language appropriate? Yes ___ No ___ If not, please describe _____

Did your child begin to develop language and later show regression? Yes ___ No ___ If yes, please describe

HEARING:

Does your child exhibit any of the following? Please check all that apply.

orients to sound _____ covers ears _____
imitates sound _____ unaware of loud sounds _____
gets overly startled by loud noise _____
does not listen to what is being said _____

PRE-SCHOOL INFORMATION:

Name of pre-school/day care (circle one or both): _____ Teacher/Director: _____

Hours attends: _____ Age at time of entrance: _____

Does your child like pre-school? Yes ___ No ___

Does your child like teacher? Yes ___ No ___

Which pre-school activities are easy for your child? _____

Which pre-school activities are difficult for your child? _____

Are there any pre-school concerns? Yes ___ No ___ If yes, please describe _____

Does your child seem to be under tension at school? Yes ___ No ___

GENERAL HEALTH:

Please list past illnesses including any history of high fever, hospitalization, surgery or significant injuries and the age at which they occurred, please include any head injuries or traumas

Health at present? _____

Is your child on any medication? Yes ___ No ___ If so, what? _____

Does your child presently suffer from any allergies or sensitivities? Yes ___ No ___ If so, what treatment has been implemented? _____

Are you vaccinating your baby? Yes ___ No ___ Were there any reactions to the vaccinations?

Yes ___ No ___ If yes, which vaccinations and at what age? _____

Name of pediatrician: _____ Telephone: _____

Is there a history of ear infections? Yes_____No_____ If so, how many times has he/she been to the doctor for ear infections and what was the treatment?_____

Has the baby had a neurological evaluation?_____ If so, by whom, when, and what was the outcome?_____

Is there a family history of diabetes, blood pressure, seizures, learning disability, visual conditions or neurological problems? Yes___No___ If yes, please describe condition and relation to your child_____

Please list any other therapies the baby is now receiving (include hours per week):

Speech _____ Occupational _____ Physical _____

Nutritional _____ Chiropractic _____ Behavioral _____

Other _____

SUMMARY:

Please describe any concerns you have about your child's behavior: _____

Briefly describe your greatest concerns about your child's development: _____

Please give a brief description of your child's personality: _____

Report filled out by: _____ Date: _____

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time during the examination. This will enable us to perform a more comprehensive evaluation of your child and to better meet your child's specific visual needs. Please bring a few of your child's favorite playthings, toys, etc to the exam. It is also recommended that both parents attend and not bring any siblings or other children to the vision examination.

It is often beneficial for us to discuss examination results and to exchange information with your child's pediatrician, day care, pre-school, and/or other professionals involved in his/her care. Please sign below to consent to exchange this information.

Consent to Release Information:

Send Reports to:

Name: _____

Address: _____

Name: _____
Address: _____

Name: _____
Address: _____

Signature of Parent or Guardian: _____