**Infant/Toddler/Pre-School Child Vision and Medical History Questionnaire** **Date:** _____

**Patient's Name** _____ **Date of Birth** _____

**The reason my child is being examined is** □ **general check up** □ **other, please explain:**

_____

**When did symptoms start:** _____
**Last eye exam was on** _____ **Where:** _____ **Glasses: Y/N Age 1st Worn** _____
**Referral By Whom** _____

| ***Does your child have any of the following:*** | | | **Explain** |
|---|---|---|---|
| **Eye turns in/out** | **Y** | **N** | _____ |
| **Squints a lot** | **Y** | **N** | _____ |
| **Covers/closes one eye a lot** | **Y** | **N** | _____ |
| **Doesn't seem to focus** | **Y** | **N** | _____ |
| **Lacks interest in looking at objects** | **Y** | **N** | _____ |
| **Rubs eyes excessively** | **Y** | **N** | _____ |
| **Eyes burn and itch** | **Y** | **N** | _____ |
| **Reddened or encrusted eyelids** | **Y** | **N** | _____ |
| **Blinks excessively** | **Y** | **N** | _____ |
| **Watery eyes** | **Y** | **N** | _____ |
| **Eyelid Droop** | **Y** | **N** | _____ |
| **Poor tracking/eye movements** | **Y** | **N** | _____ |
| **Head tilt/Face turn** | **Y** | **N** | _____ |
| **Moves objects very close to look** | **Y** | **N** | _____ |
| **Double vision** | **Y** | **N** | _____ |
| **Frequent headaches** | **Y** | **N** | _____ |
| **Eye pain** | **Y** | **N** | _____ |
| **Excess light sensitivity** | **Y** | **N** | _____ |
| **Stares at bright lights or repeatedly Flicks objects in front of face** | **Y** | **N** | _____ |
| **Stumbles over objects or is clumsy** | **Y** | **N** | _____ |
| **Poor motor control** | **Y** | **N** | _____ |
| **Any eye injury or surgery** | **Y** | **N** | _____ |
| **Any lazy eye/amblyopia** | **Y** | **N** | _____ |
| **Any patching** | **Y** | **N** | _____ |
| **Any vision therapy/orthoptics** | **Y** | **N** | _____ |

**Does your child verbalize any problems/ complaints about his/her eyes or vision? Y / N**
**If yes, explain:** _____

**Last medical exam was on** _____ **Doctor:** _____
**Current medications (dose & reason for taking)** _____
**Immunizations up to date: Y / N Any Reactions to Immunizations:** _____

| **Medical History/System Review** ***Does your child have or has your child had*** | | | **Explain** |
|---|---|---|---|
| **Allergies/ allergies to medicines** | **Y** | **N** | _____ |
| **Surgery/hospitalizations** | **Y** | **N** | _____ |
| **Cardiovascular/heart problems** High blood pressure, murmur, other | **Y** | **N** | _____ |
| **Breathing problems** | **Y** | **N** | _____ |

Asthma, shortness of breath, other

**Gastrointestinal problems** **Y** **N** _____

Food problems, diarrhea, vomiting, other

**Endocrine problems** **Y** **N** _____

Diabetes, thyroid, growth, other

**Urinary problems** **Y** **N** _____

Pain/discomfort, blood in urine, other

**Skin problems** **Y** **N** _____

Unusual rashes, excess dryness, other

**Musculoskeletal problems** **Y** **N** _____

Juvenile Rheumatoid Arthritis, other

**Neurological problems** **Y** **N** _____

High fever, seizures, balance, other

**Psychiatric/Social problems** **Y** **N** _____

Any behavior problems

**General growth/developmental: normal /delayed** _____

**Chronic fever** **Y** **N** _____

**Unexplained weight loss/gain** **Y** **N** _____

**Ear/nose/throat problems** **Y** **N** _____

Hearing loss, frequent sore throats, sinus problems

**Blood diseases** **Y** **N** _____

Bleeding disorders, sickle cell, other

**Head Injury/ Trauma** **Y** **N** _____

Bad fall, loss of consciousness

**Cancer, HIV virus, other medical conditions not noted above?** **Y** **N** _____ **Specify:** _____

**Pregnancy/ Birth History:**

**A. Length of pregnancy:** ___ less than 7 mos ___ 7- 8 mos ___ 8-9 mos ___ over 9 mos

**If your child was more than 2 weeks premature, how many weeks premature?** _____

**B. During pregnancy of this child, which, if any, of the following occurred:**

___ toxemia ___ injury by fall ___ severe illness _____other

___ trauma ___ smoking ___ prescribed medication

___ use of alcohol ___ use of drugs ___ little obstetrical care

**Please explain:** _____

**C. Type of delivery:** ___ Natural ___Caesarian ___Forceps/vacuum ___ Anesthesia ___ other

**D. Were there any problems during delivery? □ No □ Yes, explain** _____

**E. Labor during delivery lasted _____hours**

**F. Child's birth weight: _____ lbs. and ozs.**

**G. Apgar score _____@ 1 min _____ @ 5 min**

**H. My child is: _____ natural _____ adopted _____ foster _____ other_____**

**I. Mother's age at child's birth: _____** **Father's age at child's birth: _____**

**J. Immediately after birth my child was:**

**____ given oxygen**
**____ allergic**
**____ running a fever**
**____ having breathing/feeding problems**
**____ other _____**
**____ doing well, requiring no medical treatment**
**____ placed in incubator**
**____ having Rh problems**
**____ placed in neonatal ICU**
**____ jaundiced**

**Medication prescribed during first year of life: Y/ N If yes, list meds:** _____

**Developmental History**

| ACTIVITY | AVERAGE AGE | EARLY | LATE | NORMAL | UNSURE |
|---|---|---|---|---|---|
| **Gross Motor Development** | | | | | |
| 1. Head control | 3 Months | _____ | _____ | _____ | _____ |
| 2. Rolled over | 3.5 Months | _____ | _____ | _____ | _____ |
| 3. Sits w/out support | 6.5 Months | _____ | _____ | _____ | _____ |
| 4. Crawl (stomach on floor) | 7 Months | _____ | _____ | _____ | _____ |
| 5. Creep (stomach off floor) | 8 Months | _____ | _____ | _____ | _____ |
| 6. Pulls self to stand | 8 Months | _____ | _____ | _____ | _____ |
| 7. Walks unaided/alone | 12 Months | _____ | _____ | _____ | _____ |
| 8. Walks backwards | 14 Months | _____ | _____ | _____ | _____ |
| 9. Kicks a ball | 18 Months | _____ | _____ | _____ | _____ |
| 10. Walks up steps with help | 18 Months | _____ | _____ | _____ | _____ |
| 11. Toilet Trained | 24 Months | _____ | _____ | _____ | _____ |
| 12. Put on some clothing alone | 3 years | _____ | _____ | _____ | _____ |
| 13. Rides tricycle | 3 years | _____ | _____ | _____ | _____ |
| **Fine Motor Development** | | | | | |
| 1. Eye control 180 degrees | 3 Months | _____ | _____ | _____ | _____ |
| 2. Reaches/Grasp for object | 4 Months | _____ | _____ | _____ | _____ |
| 3. Neat pincer grasp | 11 Months | _____ | _____ | _____ | _____ |
| 4. Scribbles spontaneously | 15 Months | _____ | _____ | _____ | _____ |
| 5. Stacks/Piles blocks | 18 Months | _____ | _____ | _____ | _____ |
| 6. Eats with a fork/spoon | 24 Months | _____ | _____ | _____ | _____ |
| 7. Copies circle | 3 years | _____ | _____ | _____ | _____ |
| **Language Development** | | | | | |
| 1. Smiles spontaneously | 1 Month | _____ | _____ | _____ | _____ |
| 2. Responsive smile | 3-4 Months | _____ | _____ | _____ | _____ |
| 3. Responds to words/ names | 5 Months | _____ | _____ | _____ | _____ |
| 4. Says single words | 12 Months | _____ | _____ | _____ | _____ |
| 5. Refers to self by first name | 18 Months | _____ | _____ | _____ | _____ |
| 6. Combines 2 different words | 18 Months | _____ | _____ | _____ | _____ |
| 7. Says 2 word sentences | 24 Months | _____ | _____ | _____ | _____ |
| 8. Knows full name | 3 Years | _____ | _____ | _____ | _____ |

How is your child performing as compared to others his/her age:

Above average ☐ Below average ☐

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

How well does your child understand/respond to spoken language? _____

Were there any difficulties at all in feeding (such as difficulty with sucking, vomiting?)? Yes No

If yes, explain: _____

Any problems with colic? Yes No

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: _____

How many hours daily does your child sleep? _____

Does your child sleep through the night? Yes No If yes, starting at what age: _____

If no, explain: _____

What percent of the waking hours is/was your child in a playpen? _____

In a walker? _____

In a seat? _____

Did your child have a coordinated crawl and creep before he/she walked? Yes No
What things can your child do very well? _____

_____

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

_____

Was your child in Daycare/Preschool? Yes No Difficulties? _____
Does your child reverse numbers or letters? Yes No If yes, which? _____
Does your child like to draw/color? Yes No
Is your child learning to read? Yes No
Does your child like to read? Yes No

Has your child undergone any of the following testing/treatment?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Educational | Y | N | Neurological | Y | N | Psychological | Y | N |
| Occupational | Y | N | Speech/Auditory | Y | N | Physical | Y | N |

If yes, please list all previous evaluations done on your child:

| Doctor or Institution | Date(s) | Type of Evaluation | Results/Treatment/Intervention |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**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 | ☐ | Lethargic, low energy | ☐ |
| Passive | ☐ | Aggressive | ☐ |

Other (please explain): _____

**Nutritional Information**

Current Diet: Nursed ☐ Nursed until what age: _____ Bottle fed ☐
Solid food started at what age: _____ What type? _____
Are there any food allergies/sensitivities? Yes ☐ No ☐
If yes, what: _____
Activity Level: High ☐ Moderate ☐ Low ☐
Are there periods of very high energy Yes ☐ No ☐
Are there periods of very low energy? Yes ☐ No ☐
Does your child: Like sweets ☐ and/or Crave sweets ☐
If so, what? _____
What are his/her favorite foods? _____
What are his/her disliked/avoided foods? _____

| **Family History** ***Does anyone in the family/blood relative have:*** | | | **Explain** ***Who:*** |
|---|---|---|---|
| **Amblyopia/Lazy eye** | **Y** | **N** | |
| **Eye Turn / Strabismus** | **Y** | **N** | |
| **Myopia/Hyperopia as young child/infant** | **Y** | **N** | |
| **Color Vision defect** | **Y** | **N** | |

| | | | | |
|---|---|---|---|---|
| **Glaucoma** | **Y** | **N** | _____ | _____ |
| **Cataracts before age 40** | **Y** | **N** | _____ | _____ |
| **Blindness** | **Y** | **N** | _____ | _____ |
| **Tear duct problems** | **Y** | **N** | _____ | _____ |
| **Other eye problems/diseases** | **Y** | **N** | _____ | _____ |
| **High blood pressure/heart problems** | **Y** | **N** | _____ | _____ |
| **Diabetes** | **Y** | **N** | _____ | _____ |
| **Neurological diseases** | **Y** | **N** | _____ | _____ |
| **Birth defects** | **Y** | **N** | _____ | _____ |
| **Genetic or familial disorders** | **Y** | **N** | _____ | _____ |
| **Cancer** | **Y** | **N** | _____ | _____ |
| **Thyroid conditions** | **Y** | **N** | _____ | _____ |
| **Multiple sclerosis** | **Y** | **N** | _____ | _____ |
| **Epilepsy or seizures** | **Y** | **N** | _____ | _____ |
| **Learning disability** | **Y** | **N** | _____ | _____ |
| **Other medical condition not listed above** | **Y** | **N** | _____ | _____ |

**GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:**

_____

_____

_____

_____

_____

_____

Is there any other information that would be helpful/important in our evaluation or treatment of your child?

_____

_____

_____

_____

_____

_____

**Date:** _____ **Signed:** _____ **Relation to patient:** _____

**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 play things, toys, etc to the exam.**