

INFANT/TODDLER QUESTIONNAIRE

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

Appointment: Day _____ Date _____ Time _____
Patient's Name: _____

GENERAL INFORMATION

Were you referred to our office? Yes No

If yes whom may we thank for this referral? _____ Phone: _____

Address: _____

Child's Full Name: _____

Birth Date: _____ Age: _____ Male _____ Female _____
years months

Delivery Due Date: _____

Please list the names and birth dates of your family:

NAME

Father/Caretaker _____

Mother/Caretaker _____

Sibling _____ age _____

Sibling _____ age _____

Sibling _____ age _____

Sibling _____ age _____

RESPONSIBLE PERSON INFORMATION

Home Address: _____ City: _____ Zip: _____

Home Phone: _____

Father/Caretaker's Occupation: _____ Business Phone: _____

Mother/Caretaker's Occupation: _____ Business Phone: _____

Do you have Major Medical Insurance? Yes No

If so, who is the carrier? _____ Policy #: _____

Name of Insured: _____

Social Security Number: _____

MEDICAL HISTORY

Pediatrician's Name: _____ Date of Last Evaluation: _____

For what reason? _____

Results and recommendations: _____

Child's current state of health: _____

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:

Age Severe Mild Complications

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)

	<u>Patient</u>	<u>Family</u>	<u>Who</u>		<u>Patient</u>	<u>Family</u>	<u>Who</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
"Cross" or "Wall" eye	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chromosomal				Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	_____	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

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

If yes, explain: _____

Birth weight: _____ Apgar scores @ birth: _____ After 10 minutes: _____

Were forceps used? Yes No

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? _____

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? _____

VISUAL HISTORY

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

Has your child's vision been previously evaluated? Yes No

If so, Doctor's Name: _____ Date of last evaluation: _____

Reason for examination: _____

Results and recommendations: _____

Were glasses, contact lenses, or other optical devices recommended? Yes No

If yes, what? _____

Are they used? Yes No If yes, when? _____

If not used, why not? _____

Was surgery, therapy or other treatment recommended? Yes No

If yes, what? _____

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>
An eye turns in or out	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reddened or encrusted eyelids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent sties	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes in constant motion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyelids droop	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stares at bright lights or repeatedly flicks objects in front of face	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is abnormally bothered by bright light	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seems visually unaware	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Turns head to use one eye only	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tilts head to one side	<input type="checkbox"/>	<input type="checkbox"/>	_____
Moves objects very close to look at them	<input type="checkbox"/>	<input type="checkbox"/>	_____
Squints while looking at objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blinks excessively	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has tendency to rub eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Covers or closes one eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stumbles over objects or is clumsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor motor control	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lacks interest in looking at objects or seeing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unable to see distant objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unable to transfer object from hand to hand, or crossing the midline of the body	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is unable to stack blocks or other objects	<input type="checkbox"/>	<input type="checkbox"/>	_____

Does your child verbalize any problems/complaints about his/her eyes or vision? Yes No

If yes, explain: _____

PRE-SCHOOL

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

Name of Pre-school: _____ Teacher: _____ Director _____

Age at time of entrance to pre-school: _____

Does your child like pre-school? Yes No

Does your child like 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

Please explain: _____

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

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

Specifically describe any pre-school/day care concerns/difficulties: _____

Does your child seem to be under tension at pre-school/day care? Yes No

If yes, explain: _____

CURRENT ABILITIES/BEHAVIOR

Where appropriate, list the age at which your child could do the following: (some of these behaviors may not apply due to your child's chronological age).

	Age		Age
Responsive smile	_____	Stack blocks	_____
Crawl (stomach on floor)	_____	Walk alone	_____
Roll over	_____	Scribble spontaneously	_____
Creep (stomach on floor)	_____	Kick a ball	_____
Sit up alone	_____	Walk up steps with help	_____
Respond to words and names	_____	Use two-word sentences	_____
Say single words	_____	Become toilet trained	_____
Give first name	_____	Put on some clothing alone	_____

Can your child identify colors? Yes No If yes, which? _____

Can your child identify 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

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? _____

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

- | | | | |
|--------------------|--------------------------|--|--------------------------|
| Lack of curiosity | <input type="checkbox"/> | Irritable, easily upset | <input type="checkbox"/> |
| Thumb-sucking | <input type="checkbox"/> | Restlessness | <input type="checkbox"/> |
| Nervous | <input type="checkbox"/> | Has difficulty separating from parents | <input type="checkbox"/> |
| Glum, sulky, moody | <input type="checkbox"/> | Sleeplessness | <input type="checkbox"/> |
| Bad temper | <input type="checkbox"/> | Lethargic, low energy | <input type="checkbox"/> |
| Passive | <input type="checkbox"/> | Aggressive | <input type="checkbox"/> |

Other (please explain): _____

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

IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL / IMPORTANT IN THE TREATMENT OF YOUR CHILD?

RELEASE OF INFORMATION AND INSURANCE FILING

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 AUTHORIZE THIS EXCHANGE IF INFORMATION.

I agree to permit information from, or copies of, my child's examination records to be forwarded to other health care providers or insurance carriers upon their written request or upon the recommendation of GRANT VISION CARE, INC., when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims.

Parent's or Guardian's Signature

Date

This authorization is valid for the duration of treatment. Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation of your child and to better meet your child's specific visual needs.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us.

You may leave a message for us 24 hours a day 7 days a week. We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your child's visual status. To ensure your child's optimum performance we request that you arrange for siblings to have child care other than yourself, either at home or in the children's play area in the waiting room.

THANK YOU,

SINCERELY,

Drusilla H. Grant O.D., FCOVD