Grant Vision Care
1520 Portage Trail, Cuyahoga Falls, OH 44223 330-923-9951
Drusilla H. Grant O.D., FCOVD

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: ____
Male ____ Female _____
Birth Date: __________________________________ Age: ________ 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)

	Patient	Family	Who		Patient	Family	Who
Diabetes			____	High Blood Pressure			____
"Cross" or "Wall" eye			____	Learning Disability			____
Chromosomal Imbalance			____	Amblyopia (lazy eye)			____
				Multiple Sclerosis			____
Glaucoma			____	Epilepsy or Seizures			____
				Other			____

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:

Name	Age	Visual Situation

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 sties			______________________
Eyes in constant motion			______________________
Eyelids droop			______________________
Stares at bright lights or repeatedly flicks objects in front of face			______________________
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 to look at them			______________________
Squints while looking at objects			______________________
Blinks excessively			______________________
Has tendency to rub eyes			______________________
Covers or closes one eye			______________________
Stumbles over objects or is clumsy			______________________
Poor motor control			______________________
Lacks interest in looking at objects or seeing			______________________
Unable to see distant objects			______________________
Unable to transfer object from hand to hand, or crossing the midline of the body			______________________
Is unable to stack blocks or other objects			______________________

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
Thumb-sucking
Nervous
Glum, sulky, moody
Bad temper
Passive
Irritable, easily upset
Restlessness
Has difficulty separating from parents
Sleeplessness
Lethargic, low energy
Aggressive
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