Vision Development Center
Guiding Vision Beyond 20/20

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INFANT/TODDLER VISION QUESTIONNAIRE

Please fill out this questionnaire carefully. Please return it to our office prior to your appointment in the envelope provided. 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: _____ years _____ months
Delivery Due Date: _____
Please list the names and birth dates of your family:

NAME

Father/Caretaker: _____ Birth Date: _____
Mother/Caretaker: _____ Birth Date: _____
Sibling: _____ Birth Date: _____
Sibling: _____ Birth Date: _____
Sibling: _____ Birth Date: _____
Sibling: _____ Birth Date: _____

RESPONSIBLE PERSON INFORMATION
Father/Caretaker Home Address: _____ City _____ Zip _____
Home Phone _____ Cell Phone _____
Place of Employment & Position _____ Work Phone _____
Email Address _____
Mother/Caretaker Home Address _____ City _____ Zip _____
Home Phone _____ Cell Phone _____
Place of Employment & Position _____ Work Phone _____
Email Address _____
Do you have Major Medical Insurance? Yes ☐ No ☐
If so, who is the carrier? _____ Policy # _____
Name of Insured _____

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:

Immunization type _____ Date _____
Immunization type _____ Date _____
Immunization type _____ Date _____
Immunization type _____ Date _____

Any reactions to immunization(s)? Yes ☐ No ☐ _____

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 ☐

Has a neurological evaluation been performed? Yes ☐ No ☐

By whom? _____ Results & recommendations _____

Has a psychological evaluation been performed? Yes ☐ No ☐

By whom? _____ Results & recommendations _____

Has an occupational therapy evaluation been performed? Yes ☐ No ☐

By whom? _____ Results & recommendations _____

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

	Patient	**Family**	**Who**
Diabetes	☐	☐	_____
"cross" or "wall" eye	☐	☐	_____
Chromosomal imbalance	☐	☐	_____
Glaucoma	☐	☐	_____
High Blood Pressure	☐	☐	_____
Learning disability	☐	☐	_____
Amblyopia (lazy eye)	☐	☐	_____
Multiple Sclerosis	☐	☐	_____
Epilepsy or seizures	☐	☐	_____
Other	☐	☐	_____

If other, please explain _____

_____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes ☐ No ☐ _____

Did mother experience any problems during pregnancy? Yes ☐ No ☐

If yes, please explain _____

Normal birth? Yes ☐ No ☐

Were forceps used? Yes ☐ No ☐

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

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

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

If yes, please 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? _____
What things can your child do very well? _____
What things, if any, are difficult for your child? _____
_____

NUTRITIONAL INFORMATION
Current Diet: Nursed ☐ Nursed until what age _____ Bottle fed ☐
Solid food started at what age _____
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 evaluation _____
Results & 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/Relationship	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 a 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 _____
_____

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 & names	_____	Use two-word sentences	_____
Say single words	_____	Become toilet-trained	_____
Give first name	_____	Put on some clothing alone	_____

Can identify some 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	☐	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) _____
_____

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?

_____
_____
_____
_____