FAMILY VISION CARE OPTOMETRY

INFANT / TODDLER QUESTIONNAIRE

Please fill out this questionnaire *carefully* and as thoroughly as possible. There are a total of 6 pages – please be sure you have completed all six pages. You may either print a hard copy and bring it on the day of your appointment or fax it to us at 661-775-9627. THANK YOU.

Appointment: Day ________________ Date ________________ Time ________________

Patient's Name: ____ Male ☐ Female ☐

Birth Date: ______________________ Age: ______year(s) ______month(s)

Home Address: ____
Street Apt. #

____
City State Zip Code

GENERAL INFORMATION

Were you referred to our office? Yes ☐ No ☐

If yes, whom may we thank for this referral? ____

Phone: _____________________ Address: ____

Family ☐ Friend ☐ Doctor ☐ Therapist ☐

Internet ☐ Phone Book ☐ Insurance ☐ Mailing from our office ☐

Other: ____

RESPONSIBLE PERSON INFORMATION

Father/Caretaker ____________________________________

Home Phone: ______________ Business Phone: _____________ Cell phone: _______________

Father/Caretaker's Occupation: _______________________ Email address: __________________

Mother/Caretaker ____________________________________

Home Phone: ______________ Business Phone: _____________ Cell phone: _______________

Mother/Caretaker's Occupation: _______________________ Business Phone: ________________

Vision Care Insurance: ____________________________

Subscriber's SS#/Member ID #: _____________________ Birth Date of Subscriber: ______________

Do you have Major Medical Insurance? Yes ☐ No ☐

If so, who is the carrier? ______________________________ Policy #: _________________________

Name of Insured: ____

Social Security Number: ______________________________ Driver's License #: ________________

Please list the names and Birth Dates of other family members still living at home:

NAME:	Relationship:	Birth Date:
___________________________	________________________	_______________
___________________________	________________________	_______________
___________________________	________________________	_______________
___________________________	________________________	_______________

MEDICAL HISTORY

Pediatrician's Name: ____________________________ Date of Last Evaluation: ________________

For what reason? ____

Results and recommendations: ____

____

Child's current state of health: ____

Are immunizations up to date? Yes ☐ No ☐

Any reactions to immunization(s)? Yes ☐ No ☐ If yes, explain: ________________________

Medications currently using, including vitamins and supplements: None ☐

List: ____

For what condition(s)? ____

____

List illnesses, high fevers, bad falls, accidents, eye or head injuries, etc.:

Illness	Age at the time	Severity		
____________________	__________	Mild ☐	Moderate ☐	Severe ☐
____________________	__________	Mild ☐	Moderate ☐	Severe ☐
____________________	__________	Mild ☐	Moderate ☐	Severe ☐

Is your child generally healthy? Yes ☐ No ☐

If no, explain: ____

Are there any chronic problems like ear infections, asthma, or food or drug allergies? Yes ☐ No ☐

If yes, please list: ____

Is your child especially afraid of doctors? Yes ☐ No ☐

Child's dominant hand: right ☐ or left ☐? Has guidance been given in use of hand? Yes ☐ No☐

Has a neurological evaluation been performed? Yes ☐ No ☐

If yes, by whom? ____

Results: ____

Has a psychological evaluation been performed? Yes ☐ No ☐

If yes, by whom? ____

Results: ____

Has a speech and language evaluation been performed? Yes ☐ No ☐

If yes, by whom? ____

Results: ____

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

If yes, by whom? ____

Results: ____

Please indicate by checking the box whether anyone in the family has ever had any of the following and indicate who (including maternal and paternal grandparents, uncles, aunts, first cousins, mother, father, and siblings).

	Yes	**No**	**Who (please indicate which family member)**
Diabetes	☐	☐	______________
Chromosomal Imbalance	☐	☐	______________
Glaucoma	☐	☐	______________
High Blood Pressure	☐	☐	______________
Learning Disability	☐	☐	______________
Lazy eye (Amblyopia)	☐	☐	______________
Eye turn (strabismus)	☐	☐	______________
Eye tumor	☐	☐	______________
Multiple Sclerosis	☐	☐	______________
Epilepsy or Seizures	☐	☐	______________

NUTRITIONAL INFORMATION

Current Diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Does your child: Like sweets ☐ or crave sweets ☐

If yes, what types? ______________________________

Are there periods of: very high energy? Yes ☐ No ☐ very low energy? Yes ☐ No ☐

Explain: ______________________________

DEVELOPMENTAL HISTORY

Length of pregnancy? ______ weeks

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

If yes, explain: ______________________________

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

If yes, explain: ______________________________

Birth weight: ____________ Parents ages at time of birth: Mother _____ Father _____

APGAR scores @ birth (if known): ___________ After 10 minutes: ___________

Were forceps used? Yes ☐ No ☐ Was oxygen used? Yes ☐ No ☐

Was there ever any concern over your child's general growth or development? Yes ☐ No ☐

If yes, why? ______________________________

VISUAL HISTORY

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? ______________________________

Why do you feel your child needs a visual evaluation? ______________________________

How long has this problem/difficulty been observed? ______________________________

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

Have you or anyone else ever noticed any of the following happening with your baby's eyes?

	Yes	No	If yes, when?
Eyes frequently reddened	☐	☐	____________
Eye turn in ☐ out ☐	☐	☐	____________
Frequent eye rubbing	☐	☐	____________
Eyes watering	☐	☐	____________
Frequent blinking	☐	☐	____________
Swelling around the eyes	☐	☐	____________
White appearance in pupil	☐	☐	____________
Turns head to use one eye only	☐	☐	____________
Squints while looking at objects	☐	☐	____________
Poor large motor coordination	☐	☐	____________
Poor fine motor coordination	☐	☐	____________

CURRENT ABILITIES /BEHAVIOR:

Where appropriate, list the age at which your child could do the following:

If unable, please mark as N/A.

Responsive smile	_____	Stack Blocks	_____
Crawl (stomach on floor)	_____	Kick a ball	_____
Creep (on all fours)	_____	Walk up steps with help	_____
Roll Over	_____	Become toilet trained	_____
Sit up alone	_____	Put on clothing alone	_____
Stand up alone	_____	Say single words	_____
Walk alone	_____	Use two words sentences	_____
Identify colors	_____	Identify numbers/letters	_____

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

Above average ☐ Average ☐ Below average ☐

Speech: First words: ______________________________ At what age: ____________

Was early speech clear to others? Yes ☐ No ☐ Is speech clear now? Yes ☐ No ☐

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

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

Check the appropriate boxes if you have any concerns about the following behavior(s):

Lack of curiosity	☐	Irritable, easily upset	☐
Thumb-sucking	☐	Restlessness	☐
Nervousness	☐	Has difficulty separating from parents	☐
Glum, sulky, moody	☐	Sleeplessness	☐
Bad Temper	☐	Lethargic, low energy	☐
Passive	☐	Aggressive	☐

Other (please explain) :____

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

____

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