

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 #: _____

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

<u>NAME:</u>	<u>Relationship:</u>	<u>Birth Date:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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.:

<u>Illness</u>	<u>Age at the time</u>	<u>Severity</u>
_____	_____	Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>
_____	_____	Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>
_____	_____	Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>

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: _____



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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).

	<u>Yes</u>	<u>No</u>	<u>Who (please indicate which family member)</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chromosomal Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy eye (Amblyopia)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye turn (strabismus)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye tumor	<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____

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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

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

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Eyes frequently reddened	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye turn in <input type="checkbox"/> out <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent eye rubbing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes watering	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent blinking	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swelling around the eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
White appearance in pupil	<input type="checkbox"/>	<input type="checkbox"/>	_____
Turns head to use one eye only	<input type="checkbox"/>	<input type="checkbox"/>	_____
Squints while looking at objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor large motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor fine motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____

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? _____

28089 Smyth Drive ✕ Valencia CA 91355 ✕ PH: (661) 775 1860 ✕ FAX: (661) 775 9627



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

- | | | | |
|--------------------|--------------------------|--|--------------------------|
| Lack of curiosity | <input type="checkbox"/> | Irritable, easily upset | <input type="checkbox"/> |
| Thumb-sucking | <input type="checkbox"/> | Restlessness | <input type="checkbox"/> |
| Nervousness | <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) : _____

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

