

INFANT/TODDLER VISION AND MEDICAL HISTORY QUESTIONNAIRE

Please complete this questionnaire carefully and return it to our office as soon as possible.

GENERAL INFORMATION

Patient's Full Name: _____ Male Female

Birth Date: _____ Age: _____ years _____ months

School: _____ Grade level: _____

RESPONSIBLE PERSON INFORMATION

Father/Caretaker Name: _____

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

Father's E-mail Address: _____ Father's Cell Phone: _____

Mother/Caretaker Name: _____

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

Mother's E-mail Address: _____ Mother's Cell Phone: _____

Were you referred to our office? Yes No If yes, by whom: _____

MEDICAL HISTORY

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

Current medications and reason for taking them (including vitamins and supplements): _____

Drug Allergies: _____

List illnesses, bad falls, high fevers, etc. (include age at occurrence): _____

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 and/or psychological evaluation been performed? Yes No

By whom: _____ Results and recommendations: _____

Has a psychoeducational evaluation been performed? Yes No

By whom: _____ Results and recommendations: _____

Has an occupational therapy evaluation been performed? Yes No

By whom: _____ Results and recommendations: _____

Has a speech therapy evaluation been performed? Yes No

By whom: _____ Results and recommendations: _____

MEDICAL HISTORY:

	<u>Patient</u>	<u>Family</u>	<u>Relation/Details</u>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes/Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood/lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer (type)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease (asthma/emphysema)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear, nose, throat (allergies)	<input type="checkbox"/>	NA	_____
GI disease (ulcers/acid reflux)	<input type="checkbox"/>	NA	_____
Kidney, Bladder, Genital	<input type="checkbox"/>	NA	_____
Neurological	<input type="checkbox"/>	NA	_____
Acquired/Traumatic Brain Injury	<input type="checkbox"/>	NA	_____
Depression	<input type="checkbox"/>	NA	_____
Anxiety	<input type="checkbox"/>	NA	_____
Infectious disease (HIV/hepatitis)	<input type="checkbox"/>	NA	_____
Surgeries (list):	_____		

OCULAR HISTORY

	<u>Patient</u>	<u>Family</u>	<u>Relation/Details</u>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____

	<u>Patient</u>	<u>Family</u>	<u>Relation/Details</u>
Strabismus/eye turn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Amblyopia/lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye injuries	<input type="checkbox"/>	NA	_____
Eye surgeries	<input type="checkbox"/>	NA	_____
Others (list): _____			

DEVELOPMENTAL HISTORY

Full-term pregnancy: Yes No

Normal birth: Yes No Birth weight: _____

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

If yes, explain: _____

Were there any complications before, during or immediately following delivery? Yes No

If yes, explain: _____

Were forceps used? Yes No

Was there ever any reason for concern over your child's general growth or development during the first year of life? Yes No If yes, why? _____

Did your child crawl (stomach on floor)? Yes No At what age? _____

Did your child creep (on all fours)? Yes No At what age? _____

At what age did your child walk? _____ At what age did your child speak? _____

Current speech concerns? Yes No _____

VISUAL HISTORY

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

Has there been a previous vision evaluation? Yes No

If yes, Doctor's name: _____ Date of last evaluation: _____

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

If yes: Single vision Lined bifocal No-line bifocal Contact lenses

Are they worn? Yes No If yes, when? If no, why not? _____

If wearing contact lenses, what type are they? Soft Rigid Gas Permeable/Hard

Soft contact lens brand and power: _____

How many days per week are contacts worn, on average? _____

How frequently are contact lenses replaced? _____

How many nights per week are contact lenses slept in? _____

What disinfection/storage solutions are used? _____

How many years have contact lenses been worn? _____

Contact lens comfort is: Good Fair Poor

Are there any problems with current optical prescription? Yes No

If yes, explain: _____

Were any additional tests, treatments, or therapies recommended? Yes No

If yes, what? _____

Did you undergo these treatments? Yes No Explain: _____

Results and recommendations: _____

VISUAL SYMPTOMS

Please check the appropriate column for each symptom listed when wearing glasses or contact lenses (if used).

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Difficulty seeing distance objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Moves objects very close to look at them	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seems visually unaware	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lacks interest in looking at objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes itch/burn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blinks excessively	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent eye rubbing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reddened or encrusted eyelids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bothered by light	<input type="checkbox"/>	<input type="checkbox"/>	_____
An eye turns in/out/up/down	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tilts or turns head to one side excessively	<input type="checkbox"/>	<input type="checkbox"/>	_____
Covers or closes one eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Squints while looking at objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stares at bright lights	<input type="checkbox"/>	<input type="checkbox"/>	_____
Repeatedly flicks objects in front of face	<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"/>	_____
Unable to transfer object from hand to hand	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unable to cross the midline of the body	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unable to stack blocks or other objects	<input type="checkbox"/>	<input type="checkbox"/>	_____

Additional concerns: _____

PRESCHOOL

If your child attends preschool please complete the following:

Name of Preschool: _____ Age when child began preschool: _____

Is your child's school performance age appropriate? Yes No If not, explain: _____

FAMILY AND HOME

Please indicate which adult(s) patient lives with? Mother Father Stepmother

Stepfather Foster Parent(s) Adoptive Parent(s) Grandmother Grandfather

Aunt Uncle Other Caretaker (please specify): _____

Give a brief description of patient and please add any other information that would be helpful or important for our evaluation:

RELEASE OF INFORMATION AND INSURANCE FILING

IT IS OFTEN BENEFICIAL FOR US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH OTHER PROFESSIONALS INVOLVED IN YOUR CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I authorize the release of medical information to other health care providers or insurance carriers upon their written request, or upon the recommendation of ***Brier Creek Vision Care*** when it is necessary for the treatment of my visual condition or for the processing of insurance claims. This authorization shall be considered valid for the duration of my treatment. I consent that typing my name below will act as my signature.

Signature of patient or authorized representative

Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to better meet your 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. We request a minimum of 24 hour notice if you are unable to keep this appointment.

Missed appointment fee is \$75 without 24 hour notice.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your visual status.

Thank you.

The Staff of Brier Creek Vision Care & The Center for Visual Learning & Rehabilitative Therapy