



Name: _____ Male ___ Female ___ DOB: ____/____/____
Home Phone: _____ Hispanic | Caucasian | African American | Native American | Asian | Pacific Islander
Home Address: _____
Street City State Zip Code
Parent(s) or Guardian(s): _____ Adult(s) Occupation: _____
How did you learn about our program? Current patients Referred by friends/family Print Ads Radio Ads
 Website Story in Newspaper/on TV Referred by Dr. _____

Eye History

Have you ever noticed any of the following happening with your baby's eyes? (please check any that apply)
Eye turn: in out Eyes watering Eyes red Swelling around the eyes White appearance in pupil
Explain any eye concerns noted by observing child: _____

Developmental and Health History

PREGNANCY

Length of pregnancy: _____ weeks List any complications during pregnancy: _____
Other pregnancy issues: _____

DELIVERY

Birth Weight _____ Parents ages at time of birth: Mother _____ Father _____
List any complications during delivery: _____
Was oxygen used? No Yes APGAR score at birth: _____ (if known)

MEDICAL

Child's Doctor: _____ Last Exam Date: _____ Are immunizations up to date? Yes No
Does your baby have any known food or drug allergies? No Yes: _____
List ALL medications taken regularly: None List: _____
List any developmental delays: _____
Check all of the following that your baby can do at this time: Roll Over Sit Crawl Stand Walk
Has your baby ever had a high temperature (fever)? No Yes, how high? _____
Please list any childhood illnesses your baby has had:
_____ Illness _____ Age at the time. Was the illness? Mild Moderate Severe
_____ Illness _____ Age at the time. Was the illness? Mild Moderate Severe
List any accidents, eye, or head injuries, and age they occurred: _____
Please list any other conditions we should know about: _____

Family History

Do any family members have: Lazy eye (amblyopia) Yes No Eye turn (strabismus) Yes No Eye tumor Yes No
Please list any family members with a history of other eye or medical problems. List the relation and type of problem:

I acknowledge that this information is accurate to the extent that I can be certain, and will disclose additional information as necessary. This information can only be used in the management of my child's eyes and vision.

I understand that the InfantSEE™ vision assessment is without charge. If further services or treatments are recommended, I may choose any eye care professional to provide those services.

Parent/Guardian Signature _____ Date: ____/____/____

Thank you for carefully completing this confidential questionnaire. This information will allow for a more efficient use of examination time and will contribute to the understanding of infant eye and vision development.