

Name: _____ Male ___ Female ___ DOB: ___/___/___

Nickname(if any): _____ Home Phone: _____

Home Address: _____
 Street City State Zip Code

Parent(s) or Guardian(s): _____

Adult(s) Occupation: _____

How did you learn about our program? (please circle)

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 your 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 the child: _____

Developmental and Health History

PREGNANCY

Length of pregnancy: 36 weeks or more Less than 36 weeks (list weeks: ___) Pregnancy uncomplicated?

Mother's complications during pregnancy: _____ Baby issues during pregnancy: _____

DELIVERY

Birth Weight _____ APGAR score at birth: _____ (if known) Delivery uncomplicated?

Was oxygen used? No Yes List any complications during delivery: _____

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 complications of development:

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? _____

Does your baby suffer from colic? No Yes, grade: mild moderate severe

Has your baby ever had tubes in the ears? Yes No

Please list any childhood illnesses your baby has had:

_____ Illness _____ Age at the time. Was the illness? ___Mild ___Moderate ___Severe

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List any accidents, eye, or head injuries, and age they occurred: _____

Please list any other conditions we should know about: _____

Family History - Please list any family members with a history of eye or medical problems. List the relation and type of problem:

Regarding child's caretakers: Smoking: Yes No Drinking alcohol: Yes No Use of recreational drugs: Yes No

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.

 Parent/Guardian Signature

 Doctor Signature

Date: ___/___/___