

Name: \_\_\_\_\_ Male \_\_\_ Female \_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_  
 Street City State Zip Code

Parent(s) or Guardian(s): \_\_\_\_\_ Adult(s) Occupation: \_\_\_\_\_

Parent(s) or Guardian(s): \_\_\_\_\_ Adult(s) Occupation: \_\_\_\_\_

How did you learn about our program?  Current Patients  Friends/Family  Ads  
 Website  Newspaper story  Referred by Dr. \_\_\_\_\_

**Eye History**

Have you ever noticed any of the following happening with your baby's eyes? (check any that apply)

Eye turn:  in  out  Eyes watering  Eyes red  Swelling around 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: \_\_\_\_\_ *Check if pregnancy uncomplicated* \_\_\_

**Delivery**

Birth Weight \_\_\_\_\_ Parent's ages at time of birth: Mother \_\_\_\_ Father \_\_\_\_

List any complications during delivery \_\_\_\_\_

Was oxygen used? \_\_\_ No \_\_\_ Yes APGAR score at birth: \_\_\_\_ (if known) *Check if delivery uncomplicated* \_\_\_

**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: \_\_\_\_\_

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: \_\_\_ No \_\_\_ Yes

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 ALL medications taken regularly: \_\_\_ None List \_\_\_\_\_

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

Please list any other conditions or behaviors we should know about: \_\_\_\_\_

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

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

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_