Eyecare Associates, P.C.

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INFANT/PRESCHOOL QUESTIONNAIRE

Child's Name: _____Birthdate:_____Nickname:_____
Address:_____Zip Code:_____
Telephone: Home_____Work_____
Father's Name:_____Occupation:_____
Mother's Names: _____Occupation:_____
Please list other family members at home (include ages and relationships):_____
_____
Insurance Company:_____Policy:_____Referred by:_____

BEHAVIOR/VISION:

In what ways does your child seem to have visual difficulties? _____
_____
How long has the difficulty been noted?_____
Have you ever seen your child's eyes turn in or out? _____ If yes, when? _____
Have you ever been told your child has a lazy eye? _____ By whom_____
Has your child had a previous visual examination?_____ If so, by whom, when, and what was the outcome?_____
Was surgery or therapy been recommended?_____
Does anyone in your family have a lazy eye or a turned eye?_____
Does your baby exhibit any of the following? Please check all that apply.

frequently rubs the eyes_____	red, watery eyes_____
closes or covers one eye_____	blinks or squints excessively_____
turns or tilts head _____	places objects close to eyes _____
stumbles over objects _____	stares at bright lights _____
lacks interest in looking at things _____	unable to see distant objects _____
distractable or inattentive _____	appears to look through ovjects_____
has difficulty making eye contact _____	avoids near tasks _____
bothered by lights _____	tires easily _____
fearful of transitions on flooring _____	difficulty climbing _____

looks at things out of the sides of the eyes_____
repeatedly flicks objects in front of face _____
toe walks or exhibits other disturbances in gait or balance_____

DEVELOPMENTAL HISTORY:

Term of pregnancy?_____Weight at birth_____ APGAR Score:_____
Were there any complications before, during or immediately following delivery? Yes___No___ If yes, describe_____
Please describe the type of birth and any anesthetic used during the birth:_____
_____
Was your child breast or bottle fed?_____ If bottle fed, did or do you alternate feeding sides? _____
Does or did your child have colic or any allergies or sensitivities to formula?_____
_____

Have solid foods been introduced?_____At what age?_____If so, were there any reactions or allergies to any food(s)?_____
Does or did your child crawl?_____On all fours_____At what age_____
At what age did your child:
show responsive smile_____ roll over_____
sit alone _____ walk alone _____
Do you have any concerns regarding your child's social or cognitive development?
_____

SPEECH/LANGUAGE:

Age when spoke first words? _____Sentences?_____
Was speech clear to others?_____ Does your child seem to understand what is said to him/her?_____ Is language appropriate?_____ If not, please describe_____
_____
Did your child begin to develop language and later show regression? _____ If yes, please describe
_____

HEARING:

Does your child exhibit any of the following? Please check all that apply.
orients to sound_____ covers ears_____
imitates sound_____ unaware of loud sounds_____
gets overly startled by loud noise_____ does not listen to what is being said_____

GENERAL HEALTH:

Please list past illnesses including any history of high fever, hospitalization, surgery or significant injuries and the age at which they occurred, please include any head injuries or traumas.
_____
_____
Health at present?_____
Is your child on any medication? If so, what?_____
Does your child presently suffer from any allergies or sensitivities?_____ If so, what treatment has been implemented? _____
Has your baby been inoculated for DPT? Yes_____No_____
If yes, was there a reaction to the inoculation?_____Age_____
Name of pediatrician:_____
Is there a history of ear infections? Yes_____No_____ If so, how many times has he/she been to the doctor for ear infections and what was the treatment?_____
_____
Has the baby had a neurological evaluation?_____ If so, by whom, when, and what was the outcome?_____
Please list any other therapies the baby is receiving at this time (include hours per week):
Speech _____ Occupational _____ Physical _____
Nutritional_____ Chiropractic_____ Behavioral_____
Other_____

SUMMARY:

Please describe any concerns you have about your child's behavior:_____
_____
Briefly describe your greatest concerns about your child's development: _____
_____
_____
Please give a brief description of your child's personality:_____
_____
_____

Report filled out by: _____Date:_____