



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.*