Infant/Toddler Questionnaire

Sue E. Lowe, OD Gary M. Poteet, OD Amy E. Aldrich, OD

www.snowyrangevision.com

405 S 30th, Laramie, WY 82070 307-742-2020 800-480-2023 Fax: 307-742-8917

Child's Full Name_________________________________Nickname______________
Today's Date______________ Birthdate_______________Age now_______________
Parent's Name(s)____

My child is: ___ natural ___adopted ___ foster ___other(explain): _____________

At present my child is enrolled in:
__ Preschool program __Early intervention program __Resource Room in school
__ Visually Limited School Program __ Program for the Blind and Visually Handicapped
__ Mainstreamed in a regular classroom
__ Mainstreamed in a regular classroom with supplemental therapies outside the classroom
__ Home school __ Daycare __ None (infant)
__ Other: (explain)____

MEDICAL HISTORY

Pediatrician's Name:___________________ Date of Last Evaluation:__________________________________
For what reason?____
Results and recommendations:____
____
Medications currently using, including vitamins and supplements:______________________________
____

For what condition(s)?____
____
Has your child received immunizations? Yes o No o

List illnesses, bad falls, high fevers, etc.:
Age Severity Complications
____
____
____
Is your child generally healthy? Yes o No o
If no, explain:____
Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes o No o
If yes, please list:____
Has a neurological evaluation been performed? Yes o No o
By whom?____________________________________ Results and recommendations:____________________
____
Has a psychological evaluation been performed? Yes o No o
By whom?____________________________________ Results and recommendations:____________________
____
Has an occupational therapy evaluation been performed? Yes o No o
By whom? Results and recommendations:

NUTRITIONAL INFORMATION

Current Diet: Nursed o Nursed until what age:_________________ Bottle fed o
Solid food started at what age:________________ What type? ____
Are there any food allergies/sensitivities? Yes o No o
If yes, what:____
Activity Level: High o Moderate o Low o
Are there periods of very high energy Yes o No o
Are there periods of very low energy? Yes o No o
Does your child: Like sweets o and/or Crave sweets o
If so, what?____
What are his/her favorite foods?____
What are his/her disliked/avoided foods?____

PATIENT HISTORY

DEVELOPMENTAL HISTORY

Mother's age when child was born?________
How long was the pregnancy?_______weeks
During the pregnancy of the child, which if any, of the following occurred:
__ excessive nausea __ use of alcohol __staining __ use of Drugs __toxemia
__ use of megadosees of vitamins ___severe illness __ injury by falling __ regular obstetrical care
__ poor pre-natal care __trauma __ poor nutrition __smoking __ poor hygiene __ prescribed medication
__ Other: (please explain): ____
____
Labor during delivery lasted _____hours?
Labor was induced? Yes o No o
Type of delivery: __natural __ Caesarean-emergency __Scheduled C-section __forceps and/or suction utilized
Were there problems during delivery?____
____
This child's birth weight was ______lbs______ounces
Apgar scores were (only if known)________ at 1 minute and ________at 5 minutes
Immediately after birth (before leaving the hospital) my child was

__ doing well, requiring no special medical treatment
__ In need of medical attention
__ placed in an incubator for _____days
__ jaundiced
__ received oxygen
__ placed in neonatal ICU
__ having Rh problems
__ allergic

Were there any difficulties at all in feeding (such as difficulty with sucking, vomiting?) Yes o No o
If yes, explain:____
Any problems with colic? Yes o No o
Was there ever any reason for concern over your child's general growth or development? Yes oNo o
If yes, why? ____

Has your child received any special developmental guidance/ assistance? Yes o No o
If yes, explain:____
Is child's development normal in these areas (left blank means no):
__ Sitting __Creeping __ Speech __Crawling __ Walking __Emotional
How many hours daily does your child sleep?____
Does your child sleep through the night? Yes o No o If yes, starting at what age:_____________________
If no, explain:____
What percent of the waking hours is/was your child in a playpen? __ In a walker? __ In a seat? __
What things can your child do very well?____
____
What things, if any, are difficult for your child? ____
____

DEVELOPMENTAL STAGES

ACTIVITY	AVERAGE AGE	EARLY	LATE	NORMAL	UNSURE
A. Eye control 180 degrees	3 Month	______	______	_______	_______
B. Head Control	3 Months	______	______	_______	_______
C. Hand grasp	4 Months	______	______	_______	_______
D. Sits w/out Support	6.5 Months	______	______	_______	_______
E. Walks Unaided	12 Months	______	______	_______	_______
F. Scribbles Spontaneously	15 Months	______	______	_______	_______
G. Combines 2 different words	21 Months	______	______	_______	_______
H. Copies Circle	3 years	______	______	_______	_______
I. Rides Tricycle	3 years	______	______	_______	_______
J. Knows Colors	4 years	______	______	_______	_______

Can your child identify colors? Yes o No o If yes, which?______________________________________
Can your child identify numbers or letters? Yes o No o If yes, which?______________________________
What is your child's dominate hand? Right o Left o Undetermined o
Does your child like to draw/color? Yes o No o
Is your child learning to read? Yes o No o
How is your child performing as compared to others his/her age:
Above average o Average o Below Average o
How well developed is your child's spoken vocabulary?_______________________________________
How well does your child understand/respond to spoken language?_____________________________

Check the appropriate spaces if you have any concerns about the following behavior(s) in your child:

Lack of curiosity	o	Irritable, easily upset	o
Thumb-sucking	o	Restlessness	o
Nervous	o	Has difficulty separating from parents	o
Glum, sulky, moody	o	Sleeplessness	o
Bad temper	o	Lethargic, low energy	o
Passive	o	Aggressive	o

Other (please explain): ____
____

Were glasses, contact lenses, or other optical devices recommended? Yes o No o
If yes, what?____
Are they used? Yes o No o If yes, when?____
If not used, why not?____
Was surgery, therapy or other treatment recommend? Yes o No o
If yes, what?____

PRE-SCHOOL

******If your child attends preschool, please fill out the following:
Name of Pre-school:_________________________ Teacher:________________ Director:____________________
Age at time of entrance to pre-school:___________
Does your child like pre-school? Yes o No o
Does your child like teacher? Yes o No o
Compared to other children his/her age, do his/her general performance and social skills seem to be
above o equal to o or below o
Please explain:____
Which pre-school activities are easy for your child?____
____
Which pre- school activities are difficult for your child?____
____
Specifically describe any pre-school / day care concerns / difficulties:____________________________________
____
____

Does your child seem to be under tension at pre-school/day care? Yes o No o
If yes, explain:____
____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:
____
____
____
____
____
____
____

Is there any other information that would be helpful/important in our evaluation or treatment of your child?
____
____
____
____
____
____
____

Comments:

As you complete this history questionnaire you will recognize the thoroughness with which your child's problem will be considered. The office examination will take up enough time to permit a very complete optometric investigation of the problem. It is desirable to have both parents present during the evaluation. Your child's future deserves the fullest consideration that you as parents, and the staff at Snowy Range Vision can provide.

Would you like your child's pediatrician (or other health professional/teacher) to receive a copy of the results of this evaluation? If so, please sign the release of information form and fill in the names of the individuals who should receive the report.

CONSENT TO RELEASE INFORMATION

Signature ________________________________ Relation to Child ______________Date ____________

THANK YOU!!!