

## Infant/Developmental Questionnaire

- Child**
- Name: \_\_\_\_\_
  - Date of birth: \_\_\_\_\_ Age now: \_\_\_\_\_
  - Gender:  M  F
  - Parent name(s): \_\_\_\_\_
  - Child's Pediatrician: \_\_\_\_\_

- Reason for Visit**
- Eye turns in (which eye: \_\_\_\_\_)
  - Eye turns out (which eye: \_\_\_\_\_)
  - Squinting
  - Does not see things
  - Rubs eyes a lot
  - Red eyes/lids
  - General check up
  - Other: \_\_\_\_\_

- Pregnancy & labor**
- Mother's age when child was born: \_\_\_\_\_
  - Length of pregnancy: \_\_\_\_\_
  - Any complications with pregnancy:  No  Yes:  
Specify: \_\_\_\_\_
  - Any medications taken during pregnancy:  No  Yes:  
Specify: \_\_\_\_\_
  - Labor was  induced  not induced
  - Length of labor: \_\_\_\_\_
  - Delivery was:  natural  forceps and/or suction utilized  
 emergency caesarian  scheduled caesarian
  - Any complications with delivery:  No  Yes:  
Specify: \_\_\_\_\_

**Birth & early development**

- Child's birth weight: \_\_\_\_\_
- Do you know your child's apgar score?  No  Yes: \_\_\_\_\_
- Any complications with development following birth?:  No  Yes:  
Specify: \_\_\_\_\_
- Rate of learning and development has been:  fast  average  slow
- Please indicate when your child reached each stage:

Development Stage	Avg. age	Early	Normal	Late	Unsure
Eye control	4 weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head balance	16 weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hand grasp/manipulation	28 weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit, creep	40 weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand	12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk	18 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use words/phrases	20 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder/bowel control	2 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Family History**

- Check all that may apply:

	Near-sighted	Far-sighted	Astigmatism	Lazy eye	Eye turn
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\_\_\_\_\_  
Parent's signature

\_\_\_\_\_  
Date