InfantSEE™ Confidential Infant History
Assessment Date: _____/_____/_____

Name: _____ Male ___ Female___ DOB:_____/_____/_____

Nickname(if any): _____ Home Phone: _____

Home Address: _____
Street City State Zip Code

Parent(s) or Guardian(s): _____

Adult(s) Occupation: _____

How did you learn about our program? (please circle) 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: _____ ☐ *Pregnancy uncomplicated*?

DELIVERY

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

List any complications during delivery: _____

Was oxygen used? ☐ No ☐ Yes APGAR score at birth: _____ (if known) ☐ *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: _____

List ALL medications taken regularly: ☐ None List: _____

List any complications of development: _____

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? ☐ Yes ☐ No

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 any accidents, eye, or head injuries, and age they occurred:_____

Please list any other conditions we should know about:_____

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

_____

Regarding child's caretakers: Smoking: ☐ Yes ☐ No Drinking alcohol: ☐ Yes ☐ No Use of recreational drugs: ☐ Yes ☐ No

OVER

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 InfantSEE™ vision assessments are without charge. I am not required to seek additional services from this participating InfantSEE™ optometrist. If further services or treatments are recommended, I may choose any eye care professional to provide those services.

_____ Date: _____/_____/_____

Parent/Guardian Signature

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.

OVER