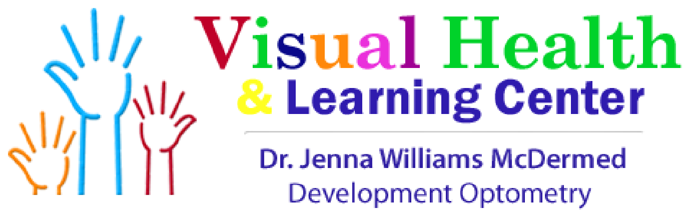

Toddler/Pre-School Questionnaire (12 months to 3 years)

Today's Date: ____________________

Patient's Full Name: ____ D.O.B.:____________ Age: _____ ☐ Male ☐ Female

Address: ____City: ________________State: _____ Zip Code: ____________

Parent Name: ______________________________________ Occupation: _______________________ Cell:________________

Parent Name: ______________________________________ Occupation: _______________________ Cell:________________

Home Phone: ______________________ Family Email: ____

School: ____ Grade: ___________

Primary Physician: ____ Phone: __________________________________

Referred by: ____

CHIEF COMPLAINT/ MAJOR CONCERN:

Briefly explain the concerns that prompted you to come to our office: ____

____

____

Who first noted visual difficulties? ________________________ When: ______________________________________

VISUAL HISTORY:

Has there been previous comprehensive visual exam? ☐ NO ☐ YES If yes, date of last exam ______/______/______

Name of Eye Doctor: ______________________________ Address: ____

Please list any unusual signs or symptoms that concern you? ____

Check all of which apply to your child:

Eye turns in/out	☐	Moves objects very close to look	☐
Squints often	☐	Reddened or encrusted eyelids	☐
Closes one eye often	☐	Frequent headaches	☐
Doesn't seem to focus	☐	Lacks interest in looking at objects	☐
Eye Pain	☐	Excess light sensitivity	☐
Rubs eyes excessively	☐	Stumbles over objects or is clumsy	☐
Eyes burn & itch	☐	Poor motor control	☐
Double vision	☐	Eye injury or surgery	☐
Blinks excessively	☐	Lazy eye/Amblyopia	☐
Watery Eyes	☐	Patching	☐
Eyelid droop	☐	Vision therapy	☐
Head tilt/Face turn	☐	Poor Tracking/eye movement	☐
Flicks objects in front of face	☐	Stares at bright lights or repeatedly	☐

Please explain any symptom checked above____

HEALTH HISTORY: ***Check any conditions that apply to your child or run in your family.***

Allergies	☐ Child	☐ Family	**Lazy Eye**	☐ Child	☐ Family
Respiratory disease	☐ Child	☐ Family	**Turned Eye**	☐ Child	☐ Family
Drug Sensitive	☐ Child	☐Family	**Glaucoma**	☐ Child	☐ Family
Cancer	☐ Child	☐Family	**Dry eyes**	☐ Child	☐ Family
Diabetes	☐ Child	☐Family	**Eyestrain**	☐ Child	☐ Family
Thyroid	☐ Child	☐ Family	**Light sensitive**	☐ Child	☐ Family
Heart problem	☐ Child	☐ Family	**Floaters/spots**	☐ Child	☐ Family
High blood pressure	☐ Child	☐ Family	**Flashing lights**	☐ Child	☐ Family
Head trauma	☐ Child	☐ Family	**Blindness**	☐ Child	☐ Family
Migraine/headache	☐ Child	☐ Family	**Cataracts**	☐ Child	☐ Family
Retinal detachment	☐ Child	☐ Family	**Eye Surgery**	☐ Child	☐ Family
Color "blind"	☐ Child	☐ Family	**Eye Injury**	☐ Child	☐ Family

Is your child currently under a physician's care? ☐ NO ☐ YES Why? ______________________________________

Date of child's last physical? ______________________ How is child's general health? ________________________

Is your child regularly taking pills or medications? ☐ NO ☐ YES Specify___________________________________

List any allergies to medications____

Is there any history of ear infection? ☐ NO ☐ YES How often?____

Is there a history of asthma? ☐ NO ☐ YES Is there a history of epilepsy or seizures? ☐ NO ☐ YES

PREGNANCY & BIRTH HISTORY

A. Length of pregnancy: ☐ Full Term ☐ Pre-Mature

B. During pregnancy, which, if any, of the following occurred:

☐ Toxemia ☐ Injury by fall ☐ Severe Illness ☐ Trauma ☐ Smoking

☐ Prescribed Medication_________________

☐ Use of Drugs ☐ Use of Alcohol ☐ Little Obstetrical Care ☐ Other

C. Type of Delivery:

☐ Natural ☐Caesarian ☐Forceps/Vacuum ☐Anesthesia ☐Other

D. Were there any problems during delivery? ☐ YES ☐NO

Explain __________________________

E. Immediately after birth my child was:

☐ Given oxygen	☐ Doing well, requiring no medical treatment
☐ Allergic	☐ Placed in an incubator
☐ Running a fever	☐ Placed in Neonatal ICU
☐ Jaundiced	☐ Having breathing/feeding problems

DEVELOPMENTAL & GENETIC HISTORY*:*

Check any conditions that apply to your child or run in your family.

ADD/ADHD	☐ Child	☐ Family	**Low Muscle Tone**	☐ Child	☐ Family
Auditory Processing Disorder	☐ Child	☐ Family	**Degenerative Disorder**	☐ Child	☐ Family
Autism Spectrum Disorder	☐ Child	☐ Family	**Sensory Related Difficulties**	☐ Child	☐ Family
Cerebral Palsy	☐ Child	☐ Family	**Down Syndrome**	☐ Child	☐ Family

*List any illnesses or developmental/genetic diagnoses not specified: ____

Activity	Average Age	Early	Late	Normal	Unable
Gross Motor Development:					
Head Control	3 Months				
Rolled Over	3.5 Months				
Sits w/o Support	6.5 Months				
Crawl(Stomach on Floor)	7 Months				
Creep (Stomach off floor)	8 Months				
Pulls self to Stand *	9 Months				
Walks with support*	12 Months				
Walks Unaided/alone*	13 Months				
Walks up steps with help	18 Months				
Runs without falling often*	20 Months				
Kicks a ball*	22 Months				
Toilet Trained	24 Months				
Walks tiptoe with Demonstration*	25 Months				
Put on some clothing alone	3 Years				
Rides Tricycle	3 Years				
Stands on one foot 2-4 seconds*	38 Months				
Fine Motor Development:					
Eye control 180 degrees	3 Months				
Reaches/Grasp for object	4 Months				
Neat pincer grasp	11 Months				
Scribbles Spontaneously	15 Months				
2 Cube Tower*	16 Months				
Turns pages 2-3 at a time*	17 Months				
Stacks/Piles blocks	18 Months				
4 Cube Tower*	19 Months				
Strings 3 one inch objects*	22 Months				
Eats with a fork/spoon	24 Months				
Turn pages one at a time*	24 Months				
Completes simple puzzle*	26 Months				
Builds 8 cube tower*	30 Months				
Puts on shoes and socks*	31 Months				
Copies Circle*	3 Years				
Language Development:					
Smiles Spontaneously	1 Month				
Responsive Smile	3-4 Months				
Responds to words/names	5 Months				
Says single words	12 Months				
4-6 Word vocabulary*	14 Months				
Refers to self by name	18 Months				
Combines 2 different words	18 Months				
Says 2 word sentences	24 Months				
10 Words in vocabulary*	28 Months				
Repeats 2 digits sequences*	29 Months				
Knows last name and sex*	32 Months				
Knows full name	3 Years				
Repeats 3 digit sequence*	39 Months				

DEVELOPMENTAL & GENETIC HISTORY (continued):

Current Skills:

Spoken Vocabulary	☐ Normal	☐ Reduced
Understanding Language	☐ Normal	☐ Reduced
Motor Development	☐ Normal	☐ Reduced

Education:

Is your child in preschool? ☐ Yes ☐ No

Does your child draw? ☐ Yes ☐ No

Does your child like to read and/or be read to? ☐ Yes ☐ No

Has your child undergone and of the following testing/treatment?

Educational	☐YES	☐NO	Neurological	☐YES	☐ NO	Psychological	☐YES	☐NO
Occupational	☐YES	☐NO	Speech/Auditory	☐YES	☐ NO	Physical	☐YES	☐NO

If yes, please list all previous evaluations done on your child:

____

____

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

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

Other(please explain): ____

Please note anything else you would like our office to know about your child here:

CHILD'S NAME____ DATE__________________

Dilation Consent

Florida Board of Optometry & the American Optometric Association recommend a dilated eye examination to fully assess the health of your eyes. Without dilation, a condition with the potential for the partial or total loss of vision may exist & go undetected. Dilation is part of a complete eye examination and does not cost extra.

Dilation will cause sensitivity to light & will make your child's near vision blurry temporarily. Our office will provide you with disposable sunglasses to minimize you sensitivity. If you have any questions, the Doctor will be happy to discuss dilation with you.

☐ **Yes, I want my child's eyes dilated today.**
☐ **No, I do not want my child's eyes dilated today, but I will reschedule the dilation.**
☐ **No, I choose not to have my child's eyes dilated.**

Acknowledgement of Receipt of Privacy Practices

I acknowledge that I have received or had access to a copy of the privacy practices at the Visual Health & Learning Center.

Signed______________________________ Relationship_____________________ Date ____________

Authorization of Treatment

I authorize my child to be examined and treated. I understand that the Visual Health & Learning Center is an Out-of-Network Provider for all Insurance Companies. Therefore, payment is required at the date of service. I am responsible to pay for services and hereby authorize release of pertinent information to insurance carriers for reimbursement directly to the patient.

Signed______________________________ Relationship_____________________ Date _______