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INFANT/TODDLER PATIENT INFORMATION FORM

Today's Date: _____

Patient's Name: _____ Appointment Date: _____ Time: _____

Were you referred to our office? Yes No If "Yes," whom may we thank for this referral? _____

If not Referred, how did you hear about us? _____

GENERAL INFORMATION

Birth Date: _____ Age: _____ Male Female Home Phone: _____

Home Address: _____ City: _____ Zip: _____

Mother/Caretaker's Name: _____ Email: _____

Employer: _____ Business Phone: _____ Cell Phone: _____

Father/Caretaker's Name: _____ Email: _____

Employer: _____ Business Phone: _____ Cell Phone: _____

YOUR CHILD'S MEDICAL HISTORY

Pediatrician's Name: _____ Is your child especially afraid of doctors? Yes No

Last Visit Date: _____ For what reason? _____ Is your child generally healthy? Yes No

Medications (include vitamins/supplements): _____

Does your child receive immunizations? Yes No Are they up-to-date? Yes No

List significant illnesses, bad falls, high fevers or chronic illnesses (asthma, allergies, frequent colds, ear infections)

Event/Condition	Age	Severity	Describe any complications

Has a neurological/psychological evaluation been performed? Yes No By whom? _____

Results and recommendations: _____

Has an occupational therapy evaluation been performed? Yes No By whom? _____

Results and recommendations: _____

YOUR CHILD'S FAMILY HISTORY Is there any history of the following? (please check if there is a history)

	<u>Patient</u>	<u>Family</u>	<u>If Family, Who?</u>		<u>Patient</u>	<u>Family</u>	<u>If Family, Who?</u>
Poor Vision/Hi Rx	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strabismus/ eye turn	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning Issue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

YOUR CHILD'S DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes No : How premature? _____ Vaginal Delivery C Section Delivery

Were there any health problems during the pregnancy/delivery for mother/child Yes No

If "Yes," explain: _____

Birth weight: _____ Apgar scores @ birth: _____ After 10 minutes: _____

Were there any difficulties at all in feeding (such as difficulty with sucking, vomiting?) Yes No

If "Yes," explain: _____

Any problems with colic? Yes No

Was there ever any reason for concern over your child's general growth or development? Yes No

If "Yes," why? _____

Has your child received any special developmental guidance/ assistance? Yes No

If "Yes," explain: _____

How many hours daily does your child sleep? _____ Does your child sleep through the night? Yes No

If "Yes," starting at what age: _____ If "No," explain: _____

What percent of the waking hours is/was your child in a: playpen? _____ walker? _____ seat? _____

What things can your child do very well? _____

What things, if any, are difficult for your child? _____

YOUR CHILD'S NUTRITIONAL INFORMATION

Current Diet: Nursed Nursed until what age: _____ Bottle fed

Solid food started at what age: _____ What type? _____

Are there any food allergies/sensitivities? Yes No If "Yes," what: _____

Activity Level: High Moderate Low

Does your child: Like sweets and/or Crave sweets If so, what? _____

What are his/her favorite foods? _____

What are his/her disliked/avoided foods? _____

YOUR CHILD'S VISUAL HISTORY

Has your child's vision been previously evaluated? Yes No If "Yes," Doctor's Name: _____ Date: _____

Results and recommendations: _____

Does your child wear: Glasses Contacts Both Worn for which activities? _____

Please check "yes" or "no" to the following observations and/or complaints as they relate to your child:

<u>Observation</u>	Yes	No	If "Yes," when?
An eye turns in or out	<input type="checkbox"/>	<input type="checkbox"/>	
Reddened or encrusted eyelids, Frequent styes	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes in constant motion	<input type="checkbox"/>	<input type="checkbox"/>	
Eyelids droop	<input type="checkbox"/>	<input type="checkbox"/>	
Stares at bright lights or repeatedly flicks objects in front of face	<input type="checkbox"/>	<input type="checkbox"/>	
Is abnormally bothered by bright light	<input type="checkbox"/>	<input type="checkbox"/>	

Seems visually unaware	<input type="checkbox"/>	<input type="checkbox"/>	
Has watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Turns head to use one eye only	<input type="checkbox"/>	<input type="checkbox"/>	
Tilts head to one side	<input type="checkbox"/>	<input type="checkbox"/>	
Moves objects very close to look at them	<input type="checkbox"/>	<input type="checkbox"/>	
Squints while looking at objects	<input type="checkbox"/>	<input type="checkbox"/>	
Blinks excessively	<input type="checkbox"/>	<input type="checkbox"/>	
Has a tendency to rub eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Covers or closes one eye	<input type="checkbox"/>	<input type="checkbox"/>	
Stumbles over objects or is clumsy	<input type="checkbox"/>	<input type="checkbox"/>	
Poor motor control	<input type="checkbox"/>	<input type="checkbox"/>	
Lacks interest in looking at objects or seeing	<input type="checkbox"/>	<input type="checkbox"/>	
Unable to see distant objects	<input type="checkbox"/>	<input type="checkbox"/>	
Unable to transfer object from hand to hand, or pass objects across the midline of the body	<input type="checkbox"/>	<input type="checkbox"/>	
Is unable to stack blocks or other objects	<input type="checkbox"/>	<input type="checkbox"/>	

Does your child verbalize any problems/complaints about his/her eyes or vision? Yes No

If "Yes," explain: _____

PRE-SCHOOL (If your child attends preschool, please answer these questions.)

Name of Pre-school: _____ Teacher: _____ Director: _____

Age at time of entrance to pre-school: _____ Does your child like pre-school? Yes No

How does your child's general performance and social skills compare to others of same age? _____

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 No If "Yes," explain: _____

CURRENT ABILITIES/BEHAVIOR

If known, list the age at which your child could do the following: (some of these behaviors may not apply to your child).

Activity	Age
Responsive smile	
Crawl (stomach on floor)	
Roll over	
Creep (stomach of floor)	
Sit up alone	
Respond to words and names	
Say single words	
Give first name	

Activity	Age
Stack blocks	
Walk alone	
Scribble spontaneously	
Kick a ball	
Walk up steps with help	
Use two-word sentences	
Become toilet-trained	
Put on some clothing alone	

Can your child identify colors? Yes No If "Yes," which? _____

Can your child identify numbers or letters? Yes No If "Yes," which? _____

Does your child like to draw/color? Yes No

Is your child learning to read? Yes No

How is your child performing as compared to others his/her age: Above average Below average

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:

- | | | |
|---|--|---|
| <input type="checkbox"/> Lack of curiosity | <input type="checkbox"/> Hyper Active, High Energy | <input type="checkbox"/> Has difficulty separating from parents |
| <input type="checkbox"/> Thumb-sucking | <input type="checkbox"/> Passive | <input type="checkbox"/> Sleeplessness |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Irritable, easily upset | <input type="checkbox"/> Lethargic, low energy |
| <input type="checkbox"/> Glum, sulky, moody | <input type="checkbox"/> Restlessness | <input type="checkbox"/> Aggressive |

Other (please explain): _____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

WHAT ARE YOUR BIGGEST CONCERNS REGARDING YOUR CHILD AT THIS TIME?

WHAT IS YOUR GOAL FOR YOUR CHILD'S VISUAL EVALUATION AND/OR VISION TRAINING?

Thank you for carefully completing this questionnaire. This information will allow for a more efficient use of time and determine your child's specific visual needs. Some infant/toddlers will need more than one appointment for consistent responses and firm diagnosis.

If you have any questions or concerns, please do not hesitate to contact us. You may leave a message for us 24 hours a day/7 days a week. We request a minimum of 24 hours notice if you are unable to keep this appointment. ***There is a \$45 rescheduling fee to reappoint a missed appointment.***

Please do not bring any other children with you because your undivided attention is necessary during the evaluation.

We are looking forward to meeting you.



Dr. Emily Schottman

Developmental Optometrist

Developmental Optometrists specialize in the testing and training of visual skills needed for proper development and school readiness.

STRABISMUS/AMBLYOPIA HISTORY

(Please complete if applicable)

Have you ever been told that your child has amblyopia ("lazy eye")? Yes No If "Yes," at what age? _____

Have you ever been told that your child has strabismus ("lazy eye")? Yes No If "Yes," at what age? _____

Have your child had an eye surgery? Yes No

Please describe the surgery, including the age surgery was performed, the number of operations, the eye(s) operated on:

Was the surgeon satisfied with the results of surgery? Yes No Explain: _____

Were you satisfied with the results of surgery? Yes No Explain: _____

Have surgical results been maintained? Yes No Explain: _____

Are you here for a second opinion regarding surgery or other treatment? Yes No

IF YOUR CHILD'S EYE TURNS:

At what age did you first notice or suspect that was an eye turning? _____

Did it begin turning suddenly or gradually ? Explain: _____

(NOTE: A SUDDEN EYE TURN MAY BE DUE A SERIOUS MEDICAL CONDITION AND REQUIRES IMMEDIATE MEDICAL ATTENTION.)

Does the eye turn in , out , up , or down ? (check all that apply)

Is the eye turn getting worse or better or is there no change ?

Is it always the same eye that turns? Yes No If "Yes," which eye? Right Left

Is the eye turn always present? Yes No If "No," under what conditions is it present? _____

Does the eye always turn the same amount? Yes No If "No," explain: _____

Do you notice if the eye turns more when your child is looking:

up close? Yes No

in the distance? Yes No

to the left? Yes No

to the right? Yes No

up? Yes No

down? Yes No

Does the eye turn less (or vision improve) when the prescription is worn? Yes No Unsure

Has your child ever used an eye patch? Yes No If "Yes," please describe the age when the patching was started, how the patching was done and for how long, the eye patched, and an estimate of the results: _____

Does one pupil ever appear to be larger than the other? Yes No

Do you ever notice one or both eyes shaking rapidly? Yes No

What is your child's best corrected vision, if known? _____

What are your biggest concerns regarding your Child's Strabismus or Amblyopia? _____