J. Robert Walesby, O.D.,F.C.O.V.D.
Shereé Wright, O.D.

WALESBY VISION CENTER
"Where Vision Is More Than Just 20/20"

Nicholas Thomas, O.D., F.C.O.V.D.
Clinical Director of Vision Therapy

INFANT/TODDLER VISION QUESTIONNAIRE

*Please fill out this questionnaire carefully & completely & submit it to our office **FOUR BUSINESS DAYS PRIOR** to your Screening or Work-Up appointment. Thank you.*

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

How did you hear about us?
Eye Doctor: _____ Address: _____
OT: _____ City, State Zip: _____
Psychologist: _____ Phone #: (____)_____ -_____
Other (specify): _____

GENERAL INFORMATION

Child's Full Name: _____ Male ☐ Female ☐
Birth Date: _____ Age: _____ years _____ months
Home Address: _____ City: _____ Zip: _____
Primary Phone #: (___)____-_____ Alternate Phone #:(___) ____-_____ Fax (_____)____-_____
Occupation Father/Guardian: _____ Work/Cell #: (____)_____-_____
Occupation Mother/Guardian: _____ Work/Cell #: (____) _____-_____
Email Father: _____ Mother: _____

FAMILY MEMBERS

NAME

Father/Guardian: _____ Birth Date: _____
Mother/Guardian: _____ Birth Date: _____
Sibling: _____ Birth Date: _____
Sibling: _____ Birth Date: _____
Sibling: _____ Birth Date: _____
Sibling: _____ Birth Date: _____

MEDICAL HISTORY

Pediatrician: _____ Date of Last Evaluation: _____
Reason For Visit: _____
Results and recommendations: _____
_____
Child's current state of health: _____
Current medications, including vitamins and supplements: _____
_____
For what condition(s): _____

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Are immunizations up to date? Yes ☐ No ☐ Opted Out ☐
Any reaction to immunizations: Yes ☐ No ☐
If yes, explain: _____

List illnesses, injuries, head trauma, high fevers, etc.:

Age	Severe/Mild	Complications

Are there any chronic problems (ear infections, asthma, hay fever, allergies, etc.)? Yes ☐ No ☐
If yes, please list: _____
Has a neurological evaluation been performed? Yes ☐ No ☐ **If yes, Please Provide a Copy**
By whom? _____ Results and recommendations: _____

Has a psychological evaluation been performed? Yes ☐ No ☐ **If yes, Please Provide a Copy**
By whom? _____ Results and recommendations: _____

Has an occupational therapy evaluation been performed? Yes ☐ No ☐ **If yes, Please Provide a Copy** By whom? Results and recommendations: _____

Is there any history of the following? (please check if there is a history):

	Patient	**Family (who)**		**Patient**	**Family (who)**
High blood pressure	☐	☐ _____	Glaucoma	☐	☐ _____
Diabetes	☐	☐ _____	Cataracts	☐	☐ _____
Thyroid Condition	☐	☐ _____	Epilepsy or Seizures	☐	☐ _____
Multiple Sclerosis	☐	☐ _____	Amblyopia (lazy eye)	☐	☐ _____
Brain Tumor	☐	☐ _____	Chromosomal Imbalance	☐	☐ _____
Other	☐	☐ _____			

If other, please explain: _____

Full-term pregnancy? Yes ☐ No ☐ _____ weeks early
Did the mother experience health problems during the pregnancy? Yes ☐ No ☐
If yes, explain: _____
Method of delivery: Cesarean Section ☐ Vaginal ☐
Complications before, during, or following delivery? Yes ☐ No ☐
If yes, explain: _____
Birth weight: ____lbs ____oz Apgar scores @ birth: _____ After 10 minutes: _____
Were forceps used? Yes ☐ No ☐ Was a Vacuum Extraction used? Yes ☐ No ☐
Was there reason for concern over his/her general growth or development? Yes ☐ No ☐
If yes, explain: _____
Has your child received any special developmental guidance/ assistance? Yes ☐ No ☐
If yes, explain: _____
How many hours daily does he/she sleep? _____
Does he/she sleep through the night? Yes ☐ No ☐ If yes, starting at what age: _____
If no, explain: _____

What percent of the waking hours is/was he/she in a playpen? _____
In a walker? _____ In a seat? _____
What things can he/she do very well? _____

_____
What things, if any, are difficult for him/her? _____

_____

NUTRITIONAL INFORMATION
Current Diet: Nursed ☐ Nursed until what age: _____ Bottle fed ☐ Solid food ☐
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 he/she: Like sweets ☐ and/or crave sweets ☐
If yes, what type(s)? _____
What are his/her favorite foods? _____
What are his/her disliked/avoided foods? _____
Are there periods of very high energy? Yes ☐ No ☐ Periods of very low energy? Yes ☐ No ☐
Explain: _____

VISUAL HISTORY
Has his/her vision been previously evaluated? Yes ☐ No ☐
If so, Doctor's Name: _____ Date of last evaluation: _____
Reason for examination: _____
Results and recommendations: _____
Were glasses, contact lenses, or other optical devices recommended? Yes ☐ No ☐
If yes, what? _____
Are they worn currently? Yes ☐ Full time ☐ Distance only ☐ Near only ☐
No ☐ explain: _____
Was surgery, therapy or other treatment recommend? Yes ☐ No ☐
If yes, what? _____

_____

Members of the family who have had visual attention (i.e. surgery) and the reason:

Name	Age	Treatment/ Condition/ Procedure

PRESENT SITUATION
Why do you feel he/she needs a visual evaluation? _____

_____
How long has this problem/difficulty been observed? _____

_____

_____

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

	Yes	No	If yes, when?
An eye turns in or out	☐	☐	
Reddened or encrusted eyelids	☐	☐	
Frequent sties	☐	☐	
Eyes in constant motion	☐	☐	
Eyelids droop	☐	☐	
Stares at bright lights or repeatedly flicks objects in front of face	☐	☐	
Is abnormally bothered by bright light	☐	☐	
Seems visually unaware	☐	☐	
Has watery eyes	☐	☐	
Turns head to use one eye only	☐	☐	
Tilts head to one side	☐	☐	
Moves objects very close to look at them	☐	☐	
Squints while looking at objects	☐	☐	
Blinks excessively	☐	☐	
Has a tendency to rub eyes	☐	☐	
Covers or closes one eye	☐	☐	
Stumbles over objects or is clumsy	☐	☐	
Poor motor control	☐	☐	
Lacks interest in looking at objects or seeing	☐	☐	
Unable to see distant objects	☐	☐	
Unable to transfer object from hand to hand, or crossing the midline of the body	☐	☐	
Is unable to stack blocks or other objects	☐	☐	

Does he/she verbalize any problems/complaints about his/her eyes or vision? Yes ☐ No ☐ If yes, explain: _____

_____

PRE-SCHOOL

If he/she attends preschool, please fill out the following:

Name of Pre-school/Daycare: _____ Location: _____

Teacher: _____ Director: _____

Age at time of entrance to pre-school: _____

Does he/she like pre-school? Yes ☐ No ☐ Does he/she like his/her teacher? Yes ☐ No ☐

Compared to other children his/her age, do his/her general performance and social skills seem to be Above average ☐ Average ☐ Below Average ☐

Please explain: _____

_____

Which pre-school activities are easy for him/her? _____

_____

Which pre- school activities are difficult for him/her? _____

_____

Specifically describe any pre-school / day care concerns / difficulties: _____

_____

_____

Does he/she seem to be under tension at pre-school/day care? Yes ☐ No ☐ If yes, explain: _____

CURRENT ABILITIES/BEHAVIOR

Where appropriate, list the age at which he/she could do the following: (some of these behaviors may not apply due to his/her chronological age).

	Age		Age
Responsive smile	_____	Stack blocks	_____
Creep (stomach on floor)	_____	Walk alone	_____
Roll over	_____	Scribble spontaneously	_____
Crawl (on all fours)	_____	Kick a ball	_____
Sit up alone	_____	Walk up steps with help	_____
Respond to words and names	_____	Use two-word sentences	_____
Say single words	_____	Become toilet-trained	_____
Give first name	_____	Put on some clothing alone	_____

Can he/she identify colors? Yes ☐ No ☐ If yes, which? _____

Can he/she identify numbers or letters? Yes ☐ No ☐ If yes, which? _____

Does he/she like to draw/color? Yes ☐ No ☐ Is he/she learning to read? Yes ☐ No ☐

How is he/she performing as compared to others his/her age:

Above average ☐ Average ☐ Below average ☐

How well developed is his/her spoken vocabulary? _____

How well does he/she understand/respond to spoken language? _____

Check the appropriate spaces if you have any concerns about the following behavior(s) in him/her:

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

Other (please explain): _____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD. INCLUDE INFORMATION THAT MAY BE HELPFUL IN HIS/HER TREATMENT/ DIAGNOSIS: _____

RELEASE OF INFORMATION AND INSURANCE FILING

IT IS OFTEN BENEFICIAL FOR US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH YOUR CHILDS PEDIATRICIAN, SCHOOL, OR OTHER PROFESSIONALS INVOLVED IN HIS/HER CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I agree to permit copies of my child's examination records to be forwarded to other health care providers or insurance carriers upon written request or recommendation of the WALESBY VISION CENTER when deemed necessary for treatment of his/her visual condition, or processing of insurance claims.

_____ _____

Parent's or Guardian's Signature Date

I do hereby give my permission to the WALESBY VISION CENTER to treat _____
(Child's Name)

_____ _____

Parent's or Guardian's Signature Date

This authorization is valid for the duration of treatment. Thank you for carefully completing this questionnaire. The information provided allows for a more efficient use of time, enabling us to perform a more comprehensive evaluation and better meet his/her specific visual needs.

If you have questions or concerns prior to your appointment, please do not hesitate to contact us.

A minimum cancellation notice of 48 hours is required, as previously agreed, or a $360 service charge will be processed. You may leave a voicemail at our office number at any time.

Please be prompt for the appointment, in order to maximize the time reserved to evaluate his/her visual status.

Your undivided attention is necessary during this evaluation; it is, therefore, advisable not to bring other children.

Your child may benefit from bringing something to occupy his/her time while you are in conference with the doctor.

Sincerely,

J. Robert Walesby, O.D., F.C.O.V.D.
Shereé Wright, O.D.

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Clincial Director of Vision Therapy

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