PHILIP J. SCHAVILLE, O.D., P.C.
Doctor of Optometry

Parent Questionnaire
Infants, Toddlers & Preschoolers

Child's Name______________________ Nickname_____________

Birthdate_______________ Age Now____________

Parent's Name(s)______________________ Occupation (s)_____________

Is Child Presently Attending School? ______

Name of School___________________________ Hours Attending________

My Child Is Here Today Because:

____ Eye Drifts In
____ Eye Drifts Out
____ Squints
____ Rubs eyes
____ Bumps Into Things
____ Red Eyes

_____Routine Check - No Problems
_____Vision Problems in Family
_____Second Opinion
_____Recheck Examination
_____ Other________________________
____

My Child Is: ____Natural _____Adopted _____Foster _____Other

Family Vision History

Does anyone in the family have:

	Relationship to child
_____Nearsightedness	____________________
_____Farsightedness	____________________
_____Astigmatism	____________________
_____Amblyopia (lazy eye)	____________________
_____Strabismus (Eye turn)	____________________
_____Blindness	____________________
_____Eye Disease	____________________
_____Other	____________________

Has your child received any previous vision care?

	Approximate Date	By Whom
_____Glasses	____________	____________
_____Patching	____________	____________
_____Medication	____________	____________
_____Surgery	____________	____________
_____Therapy	____________	____________

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Pregnancy

How long was the pregnancy?

_____Less than 7 months
_____between 7 and 8 months
_____between 8 and 9 months
_____over 9 months

Please check which of the following occurred during pregnancy?

_____excessive vomiting
_____excessive staining/blood loss
_____infection(s)
_____toxemia
_____operation(s)
_____other illnesses
_____prescribed medications
_____x-rays during pregnancy
_____other____

_____smoking
_____use of alcohol
_____use of drugs
_____regular obstetrical care
_____little medical care
_____poor nutrition
_____poor hygiene

Delivery

Was Labor: _____Induced _____Spontaneous
_____Forceps _____High _____Mid _____Low
Duration of labor:__________ hours
Type of delivery: _____Normal _____Breach _____Caesarean

Complications (check those which apply)

_____cord around neck
_____cord presented first
_____hemorrhage
_____Infant injured during delivery
_____Other (specify)_____________________________________

Post Delivery Period

_____Birth Weight
_____APGAR score
_____Total number of days baby was in hospital after delivery
_____Jaundice
_____Incubator care/need for oxygen ____number of days
_____Infections
_____Sucking problems
_____Breathing difficulty
_____Swallowing difficulty
_____Birth defects

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Infancy/Toddler Period

Were any of the following present to a significant degree?

_____Did not enjoy cuddling
_____Was not calmed by begin held and/or stroked
_____Colic
_____Excessive restlessness
_____Diminished sleep because of restlessness & easy arousal
_____Frequent headbanging
_____Constantly into everything
_____Excessive number of accidents compared to other children

General Health/Developmental History

Check those items which pertain to your child:

_____asthma, eczema or allergies
_____significant or frequent illnesses
_____history of epilepsy or seizures
_____hospitilizations (other than at birth)
_____diagnosed as developmentally delayed   Diagnosis_______________
_____previous injuries or accidents
_____medical condition and/or surgery
_____HIV positive

Is your child's development normal in: (average)

Sitting	_____Yes	_____No	(5 - 8 months)
Crawling	_____Yes	_____No	(5 - 8 months)
Walking	_____Yes	_____No	(11-15 months)
Speech	_____Yes	_____No	(single words 12-22 months)
Emotional	_____Yes	_____No	

Has your child undergone any of the following testing:

_____Psychological
_____Nutritional
_____Lead levels
_____Developmental
_____Neurological
_____Speech/Language Evaluation
_____Physical Therapy Evaluation
_____Occupational Therapy Evaluation

Has an MRI or CAT scan been performed?______

What was the date of your child's last medical exam?_______________

What are your child's favorite toys, games and songs?

Is there anything your child is fearful of?

Is there any additional information you would like us to know about your child? (Please feel free to use the back of this paper if necessary)

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