LODESTAR
FAMILY EYE CARE, PC

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GUIDING YOU TO BETTER VISION

INFANT/TODDLER DEVELOPMENTAL HISTORY FORM

Thank you for carefully completing this questionnaire. The information supplied will allow for more efficient use of time and will permit us to make a complete optometric evaluation of your child's visual system related to his/her specific needs.

GENERAL INFORMATION:

Full Name: ______________________________ Preferred Name: ________________

Child Date of Birth: ___________________________ Sex: ☐ Male ☐ Female Age: _______

Address: ____ Suite/Apt#: __________

City: ____________________________________ State: _______ Zip: __________

Phone (home):______________________ Referred By: ________________________

Is your child especially afraid of doctors? ☐ Yes ☐ No

Father's/Guardian's Contact Information:

Name: ____

E-mail Address: ____

Contact Number: ______________________________________ Ok to text?: Yes ☐ No ☐

Employer: ____

Mother's/Guardian's Contact Information:

Name: ____

E-mail Address: ____

Contact Number: ______________________________________ Ok to text?: Yes ☐ No ☐

Employer: ____

REASON FOR TODAY'S VISIT: ____

____

Please check YES or NO to the following observations and/or concerns as they relate to your child:

☐ Yes ☐ No - Eyes crossed, turning in or out at any time or eyes that do not appear straight, especially when child is tired - If yes, when? _____________
☐ Yes ☐ No – Does the child transfer objects from hand to hand, crossing the middle of the body - If yes, when? _____________
☐ Yes ☐ No - Thrusts head forwards/backwards while looking at distant objects - If yes, when? _________
☐ Yes ☐ No - Lacks interest in looking at objects or seeing - If yes, when? _____________
☐ Yes ☐ No - Unable to stack blocks or other objects - If yes, when? _____________
☐ Yes ☐ No - Abnormally bothered by bright lights - If yes, when? _____________
☐ Yes ☐ No - Complains of burning or itching eyes - If yes, when? _____________
☐ Yes ☐ No - Turns the head to use one eye only - If yes, when? _____________
☐ Yes ☐ No - Stares at bright lights frequently - If yes, when? _____________
☐ Yes ☐ No - Squints while looking at objects - If yes, when? _____________
☐ Yes ☐ No - Has reddened eyes or eyelids - If yes, when? _____________
☐ Yes ☐ No - Unable to see distant objects - If yes, when? _____________
☐ Yes ☐ No - Has a tendency to rub eyes - If yes, when? _____________
☐ Yes ☐ No - White appearance in pupil - If yes, when? _____________
☐ Yes ☐ No - Complains of pain in eyes - If yes, when? _____________
☐ Yes ☐ No - Tilts the head to one side - If yes, when? _____________
☐ Yes ☐ No - Covers or closes one eye - If yes, when? _____________
☐ Yes ☐ No - Eyes in constant motion - If yes, when? _____________
☐ Yes ☐ No - Stumbles over objects - If yes, when? _____________
☐ Yes ☐ No - Has encrusted lids - If yes, when? _____________
☐ Yes ☐ No - Has frequent sties - If yes, when? _____________
☐ Yes ☐ No - Blinks excessively - If yes, when? _____________
☐ Yes ☐ No - Has watery eyes - If yes, when? _____________
☐ Yes ☐ No - Eyelids droop - If yes, when? _____________

DEVELOPMENTAL HISTORY

Birth weight: ____________ Full term pregnancy? ☐ Yes ☐ # Weeks: __________ Normal birth? ☐ Yes ☐ No

Did the mother have any health difficulties during the pregnancy? ☐ Yes ☐ No
Were forceps used? ☐ Yes ☐ No Any birth complications? ☐ Yes ☐ No Is this an adopted child? ☐ Yes ☐ No

Any special circumstances we should be aware of? ☐ Yes ☐ No If yes, explain: _________________________

____

Is your child alert? ☐ Yes ☐ No If no, explain: ____

Is your child meeting all developmental milestones? ☐ Yes ☐ No If no, explain: ____________________

____

____

Was there ever a reason for concern over your child's general growth or development?

If yes, why? ____

____

____

OCULAR HISTORY

Previous Eye Doctor: ______________________ Last eye exam: __________

Results: ____

History of eye injuries: ____

History of eye diseases: ____

How much time does your child spend doing the following in an average day?

Reading: ______ hrs Computer/electronics: _______ hrs Watch TV: _______ hrs Gaming: _______ hrs

Immediate members of the family who have had visual attention and why:

Name	Age	Visual situation

MEDICAL HISTORY

Pediatrician: ______________________ Has your child been prone to infections? ☐ Yes ☐ No

Chronic problems like hay fever, asthma, or allergies? ☐ Yes ☐ No

List illnesses, bad falls, high fever, asthma or allergies: ______________________

Age	Condition	Mild/Severe

FAMILY HISTORY

Do any family members have: Lazy eye ☐ Yes ☐ No Eye turn ☐ Yes ☐ No Eye tumor ☐ Yes ☐ No

Please list family members with a history of other eye or medical problems. Please list the relationship, age and type of problem:

Relationship	Age	Visual/Medical Problem

GENERAL BEHAVIOR

Do you have any concerns about your child's behavior? ☐ Yes ☐ No

If so, what are they? ______________________________

Has there been any recent or ongoing emotional difficulties? ☐ Yes ☐ No

If so, describe: ______________________________

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

☐ Lack of curiosity

☐ Thumb sucking

☐ Nervous

☐ Glum, sulky, moody

☐ Bad temper

☐ Irritable, easily upset

☐ Restlessness

☐ Has difficulty separating from parents

☐ Sleeplessness

☐ Other: ______________________________

Print Name: ______________________________ Date: ______________

Signature: ______________________________