InfantSEE™ Confidential Infant History
Assessment Date: _____/_____/_____

Name: _____ Male ___ Female___ DOB:_____/_____/_____

Nickname(if any): _____ Home Phone: _____

Home Address: _____
Street City State Zip Code

Parent(s) or Guardian(s): _____

Adult(s) Occupation: _____

How did you learn about our program? (please circle) Current patients Referred by friends/family Print Ads Radio Ads Website Story in Newspaper/on TV Referred by Dr._____

Eye History
Have you ever noticed any of the following happening with your baby's eyes? (please check any that apply)

Eye turn: ☐ in ☐ out ☐ Eyes watering ☐ Eyes red ☐ Swelling around the eyes ☐ White appearance in pupil

Explain any eye concerns noted by observing child: _____

_____

Developmental and Health History

PREGNANCY

Length of pregnancy: _____ weeks List any complications during pregnancy: _____

Other pregnancy issues: _____ ☐ *Pregnancy uncomplicated?*

DELIVERY

Parent's ages at time of birth: Mother _____ Father _____ Birth Weight _____

List any complications during delivery: _____

Was oxygen used? ☐ No ☐ Yes APGAR score at birth: _____ (if known) ☐ *Delivery uncomplicated?*

MEDICAL

Child's Doctor: _____ Last exam Date: _____ Are immunizations up to date? ☐ Yes ☐ No

Does your baby have any known food or drug allergies? ☐ No ☐ Yes: _____

List ALL medications taken regularly: ☐ None List: _____

List any complications of development: _____

Check all of the following that your baby can do at this time: ☐ Roll Over ☐ Sit ☐ Crawl ☐ Stand ☐ Walk

Has your baby ever had a high temperature (fever)? ☐ No ☐ Yes, how high? _____

Does your baby suffer from colic? ☐ No ☐ Yes, grade: ☐ mild ☐ moderate ☐ severe

Has your baby ever had tubes in the ears? ☐ Yes ☐ No

Please list any childhood illnesses your baby has had:

_____ Illness _____Age at the time. Was the illness? __Mild __Moderate __Severe

_____ Illness _____Age at the time. Was the illness? __Mild __Moderate __Severe

List any accidents, eye, or head injuries, and age they occurred:_____

Please list any other conditions we should know about:_____

Family History - Please list any family members with a history of *eye or medical* problems. List the relation and type of problem:

_____

Regarding child's caretakers: Smoking: ☐ Yes ☐ No Drinking alcohol: ☐ Yes ☐ No Use of recreational drugs: ☐ Yes ☐ No

I acknowledge that this information is accurate to the extent that I can be certain, and will disclose additional information as necessary. This information can only be used in the management of my child's eyes and vision.

I understand that InfantSEE™ vision assessments are without charge. I am not required to seek additional services from this participating InfantSEE™ optometrist. If further services or treatments are recommended, I may choose any eye care professional to provide those services.

_____ Date: _____/_____/_____

Parent/Guardian Signature

Thank you for carefully completing this confidential questionnaire. This information will allow for a more efficient use of examination time and will contribute to the understanding of infant eye and vision development.

The following is a questionnaire for the parent/guardian to fill out at the InfantSEE® exam. Answers to the questions will not impact the examination by the optometrist:

Demographic:

1. Sex of Baby: ☐ Male or ☐ Female
2. Ethnic Origin: ☐ Asian ☐ Caucasian ☐Hispanic ☐African-American
   ☐Native American ☐Pacific Islander Other_____
3. Was your baby premature? ☐Yes ☐No. If yes, how many weeks early_____
4. Age of mother at baby's birth _____
5. If full-term, any complications with delivery?
   _____
6. Your baby primarily lives with:
   - ☐ One parent
   - ☐ Two parents
   - ☐ Other _____
7. What is your zip code? _____
8. How far did you travel to the optometrist's office for your infant to have an exam?
   _____Miles OR _____Minutes
9. Does your family have a history of wearing contacts or eyes glasses? Please circle all that apply
   - ☐ Parent
   - ☐ Sibling
   - ☐ Other_____
   - ☐ No
10. Is there a family history of eye/ vision problems? Please circle all that apply.
    - ☐ Parent _____
    - ☐ Sibling _____
    - ☐ Other -Please explain _____
    - ☐ No
11. Does your baby have medical insurance coverage? (You will not be billed for this assessment; the question is for information only) Circle all that apply.
    - ☐ Private
    - ☐ CHIP or similar state children's health care program
    - ☐ Medicaid
    - ☐ None
    - ☐ Other_____

InfantSEE® Program

1. Had you heard of the InfantSEE® program before the promotion of InfantSEE® Week?
   - ☐ Yes
   - ☐ No

2. How did you hear about the InfantSEE® Week Project? (Circle all that Apply)
   - ☐ TV
   - ☐ Radio
   - ☐ Mailing/Flyer
   - ☐ Internet Search
   - ☐ Word of Mouth
   - ☐ Other_____

3. Did you plan on taking your infant to the optometrist's office for an eye examination prior to 1 year of age?
   - ☐ Yes
   - ☐ Possibly
   - ☐ No

4. Have you told your pediatrician or family physician about something unusual with your infant's eyes?
   - ☐ Yes, but the doctor told me not to worry about it
   - ☐ Yes, and the baby was referred to an eye doctor
   - ☐ No

5. Does your baby have routine well-baby examinations?
   - ☐ Yes, with a Pediatrician
   - ☐ Yes, with a Family Physician
   - ☐ Yes, with a Nurse Practitioner
   - ☐ Yes, Other – Please explain_____
   - ☐ No

6. Have you taken a child in the family under the age of 2 to see an eye doctor in the past?
   - ☐ Yes
   - ☐ No
   - ☐ No other children

Circle the best answer to the below questions:

1) The earlier a child's vision problem is identified, the more responsive he/she is to treatment. True False

2) Vision defects are the leading handicapping condition in children. True False

3) Visual problems can be associated with behavioral issues in children. True False

After the Assessment:

1) Do you feel this vision assessment was a positive experience?
   - ☐ Yes
   - ☐ No
   - ☐ Comment_____

2) Will you tell your friends to have their baby's vision checked through the InfantSEE® Program?
   - ☐ Yes
   - ☐ No

3) Do you understand the need for dilation drops to complete the assessment?
   - ☐ Yes
   - ☐ Somewhat
   - ☐ No

4) How long did the assessment take?
   - ☐ 5-10 minutes
   - ☐ 10-15 minutes
   - ☐ 15-20 minutes
   - ☐ 20 or more minutes

Additional Comments:_____
_____
_____
_____

Thank you for your participation in this survey.

Please remember to have your child's next vision exam at age 3 unless the doctor tells you differently.