InfantSEE™

INSIGHT EYECARE
FAMILY EYE CARE · FASHION FRAMES · CONTACT LENSES · LASIK CO-MANAGEMENT

InfantSEE™ Confidential Infant History
Assessment Date:

Name: _____ Male ☐ Female ☐ DOB: _____

Home Phone: _____ Hispanic | Caucasian | African American | Native American | Asian | Pacific Islander

Home Address: _____ Las Vegas Nevada _____
Street City State Zip Code

Parent(s) or Guardian(s): _____ Adult(s) Occupation: _____

How did you learn about our program? ☐ 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: _____

DELIVERY

Birth Weight _____ Parents ages at time of birth: Mother _____ Father _____

List any complications during delivery: _____

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

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 developmental delays: _____

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? _____

Please list any childhood illnesses your baby has had:

_____ Illness _____Age at the time. Was the illness? ☐ Mild ☐ Moderate ☐ Severe

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

Please list any other conditions we should know about: _____

Family History

Do any family members have: Lazy eye (amblyopia) ☐ Yes ☐ No Eye turn (strabismus) ☐ Yes ☐ No Eye tumor ☐ Yes ☐ No

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

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 the InfantSEE™ vision assessment is without charge. 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.