INFANT / TODDLER SYMPTOM CHECKLIST

KELLY VISION CENTER
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Child's Name: _____

Today's Date ____ /_____ /_____

Do you notice any of the following in your child? "*Please Check the following if it applies to your child*"

- ☐ Head Tilt or turning head to use one eye
- ☐ An eye turns in or out
- ☐ Covers or closes one eye
- ☐ Red or encrusted eyes or eyelids
- ☐ Eyelids droop
- ☐ Stares at bright lights or repeatedly flicks objects in front of face
- ☐ Is abnormally bothered by bright lights
- ☐ Excessive watering of eyes
- ☐ Blinks excessively
- ☐ Has a tendency to rub eyes
- ☐ Eyes in constant motion
- ☐ Seems visually unaware of surroundings
- ☐ Moves objects very close to look at them
- ☐ Squints while looking at objects
- ☐ Unable to see distant objects
- ☐ Stumbles over objects or is clumsy
- ☐ Poor motor control
- ☐ Lacks interest in looking at objects or seeing
- ☐ Unable to transfer object from hand to hand or pass objects across the midline of body
- ☐ Is unable to stack blocks or other objects

1) Did your child have any complications during birth? ☐ YES ☐ NO

_____

_____

2) Is the child developmentally delayed in any areas? Speech? Language? Fine motor control?

_____

_____

3) Has patient been diagnosed with strabismus or amblyopia? ☐ Strabismus ☐ Amblyopia

4) List all childhood illnesses…

_____

_____

5) Does your child attend a preschool program or daycare? ☐ YES ☐ NO