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DEVELOPMENTAL HISTORY QUESTIONNAIRE

Date: ________________________

Patient's Name _________________________________ **Date of Birth** _________________

School____ **Grade** _________

Pediatrician: ___________________________ **Referral By Whom** ______________________________________

The reason my child is being examined is ❒ general check up ❒ other, please explain: _______________

____

When did symptoms start: ____

Last eye exam was on ________________________ **Where:** ____

Glasses: Y / N Age 1st Worn___________

Does your child have any of the following:			**Explain**
Eye turns in/out	Y	N	____
Squints a lot	Y	N	____
Covers/closes one eye a lot	Y	N	____
Doesn't seem to focus	Y	N	____
Lacks interest in reading/near activities	Y	N	____
Rubs eyes excessively	Y	N	____
Eyes burn and itch	Y	N	____
Reddened or encrusted eyelids	Y	N	____
Blinks excessively	Y	N	____
Watery eyes	Y	N	____
Eyelid Droop	Y	N	____
Poor tracking / eye movements	Y	N	____
Head tilt/Face turn	Y	N	____
Moves objects very close to look	Y	N	____
Double vision	Y	N	____
Frequent headaches	Y	N	____
Eye pain	Y	N	____
Excess light sensitivity	Y	N	____
Stares at bright lights or repeatedly flicks objects in front of face	Y	N	____
Stumbles over objects or is clumsy	Y	N	____
Poor motor control	Y	N	____
Any eye injury or surgery	Y	N	____
Any lazy eye/amblyopia	Y	N	____
Any patching	Y	N	____
Any vision therapy/orthoptics	Y	N	____

Does your child verbalize any problems/ complaints about his/her eyes or vision? Y / N *(over)*

If yes, explain: ____

Last medical exam was on _______________ Doctor: ______________________________

Current medications (dose & reason for taking) ______________________________

Immunizations up to date: Y / N Any Reactions to Immunizations:______________________

PREGNANCY/ BIRTH HISTORY:

A. My child is: ❒ natural ❒ adopted ❒ foster ❒ other_____________

B. Length of pregnancy: ❒ less than 7 mos ❒ 7- 8 mos ❒ 8-9 mos ❒ over 9 mos

C. During pregnancy of this child, which, if any, of the following occurred:

❒ toxemia ❒ injury by fall ❒ severe illness ❒ other _____________
❒ trauma ❒ smoking ❒ prescribed medication
❒ use of alcohol ❒ use of drugs ❒ little obstetrical care

Please explain: ____

D. Type of delivery: ❒ Natural ❒ Caesarian ❒ Forceps/vacuum ❒ Anesthesia
❒ other____

E. Were there any problems during delivery? ❒ **No** ❒ **Yes, explain:**______________________

____

F. Labor during delivery lasted ______hours

F. Child's birth weight: _____________ lbs. and ozs.

G. Apgar score _____@ 1 min _____ @ 5 min

H. Mother's age at child's birth: _______ Father's age at child's birth: ________

I. Immediately after birth my child was:

❒ given oxygen ❒ doing well, requiring no medical treatment
❒ allergic ❒ placed in incubator
❒ running a fever ❒ having Rh problems
❒ having breathing/feeding problems ❒ placed in neonatal ICU
❒ jaundiced ❒ other ______________________

Medication prescribed during first year of life: Y/ N If yes, list meds: ______________________

DEVELOPMENTAL HISTORY

ACTIVITY	**AVERAGE AGE**	**EARLY**	**LATE**	**NORMAL**	**UNSURE**
Gross Motor Development					
1. Head control	3 Months	______	______	______	______
2. Rolled over	3.5 Months	______	______	______	______
3. Sits w/out support	6.5 Months	______	______	______	______
4. Crawl (stomach on floor)	7 Months	______	______	______	______
5. Creep (stomach off floor)	8 Months	______	______	______	______
6. Pulls self to stand	8 Months	______	______	______	______
7. Walks unaided/alone	12 Months	______	______	______	______
8. Walks backwards	14 Months	______	______	______	______
9. Kicks a ball	18 Months	______	______	______	______
10. Walks up steps with help	18 Months	______	______	______	______
11. Toilet Trained	24 Months	______	______	______	______
12. Put on some clothing alone	3 years	______	______	______	______
13. Rides tricycle	3 years	______	______	______	______

(cont)

ACTIVITY	AVERAGE AGE	EARLY	LATE	NORMAL	UNSURE
Fine Motor Development					
1. Eye control 180 degrees	3 Months	______	______	______	______
2. Reaches/Grasp for object	4 Months	______	______	______	______
3. Neat pincer grasp	11 Months	______	______	______	______
4. Scribbles spontaneously	15 Months	______	______	______	______
5. Stacks/Piles blocks	18 Months	______	______	______	______
6. Eats with a fork/spoon	24 Months	______	______	______	______
7. Copies circle	3 years	______	______	______	______
Language Development					
1. Smiles spontaneously	1 Month	______	______	______	______
2. Responsive smile	3-4 Months	______	______	______	______
3. Responds to words/ names	5 Months	______	______	______	______
4. Says single words	12 Months	______	______	______	______
5. Refers to self by first name	18 Months	______	______	______	______
6. Combines 2 different words	18 Months	______	______	______	______
7. Says 2 word sentences	24 Months	______	______	______	______
8. Knows full name	3 Years	______	______	______	______

- How is your child performing as compared to others his/her age: ❒ Above average ❒ Below average
- Were there any difficulties at all in feeding (such as difficulty with sucking, vomiting)? ❒ Yes ❒ No
  If yes, explain: ______________________________
- Any problems with colic? .... ❒ Yes ❒ No
- Was there ever any reason for concern over your child's general growth or development? ❒ Yes ❒ No
  If yes, why? ______________________________
- Has your child received any special developmental guidance/ assistance? .... ❒ Yes ❒ No
  If yes, explain: ______________________________
- How many hours daily does your child sleep? ____________
- Does your child sleep through the night? .... ❒ Yes ❒ No
  If yes, starting at what age: ______________
  If no, explain: ______________________________
- Did your child have a coordinated crawl and creep before he/she walked? .... ❒ Yes ❒ No
- Does your child like to draw/color? .... ❒ Yes ❒ No
- Is your child learning to read? .... ❒ Yes ❒ No
- What things can your child do very well? ______________________________
____
- What things, if any, are difficult for your child? ______________________________
____
- What difficulties are your child experiencing in school?
____

Has your child undergone any of the following testing/treatment?

Educational	Y	N	Neurological	Y	N	Psychological	Y	N
Occupational	Y	N	Speech /Auditory	Y	N	Physical	Y	N

If yes, please list all previous evaluations done on your child: *(next page)*

Doctor or Institution	Date(s)	Type of Evaluation	Results/Treatment/Intervention
________________	________	________________	______________________
________________	________	________________	______________________
________________	________	________________	______________________
________________	________	________________	______________________

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

❒ Lack of curiosity
❒ Thumb-sucking
❒ Nervous
❒ Glum, sulky, mood
❒ Bad temper
❒ Passive
❒ Irritable, easily upset
❒ Restlessness
❒ Has difficulty separating from parents
❒ Sleeplessness
❒ Lethargic, low energy
❒ Aggressive
❒ Other (please explain): ____

NUTRITIONAL INFORMATION

Current Diet: ____

❒ Nursed. Until age: _________ ❒ Bottle fed

Solid food started at what age: ________ What type? ______________________________

Are there any food allergies/sensitivities? ❒ Yes ❒ No

If yes, what: ____

Does your child: ❒ Like sweets ❒ Crave sweets If so, what? ______________________

What are his/her favorite foods? ______________________________________

What are his/her disliked/avoided foods? ______________________________________

Activity Level: .... ❒ High ❒ Moderate ❒ Low

Are there periods of very high energy? ❒ Yes ❒ No If so, when ______________

Are there periods of very low energy? ❒ Yes ❒ No If so, when ______________

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

____
____
____
____

Is there any other information that would be helpful/important in our evaluation or treatment of your child?

____
____
____
____

Name of Parent(s) / Guardian(s): ______________________ ______________________

(In case Doctor has questions) **Phone :** ______________________ **E-Mail:** ______________________

Thank you for carefully completing this questionnaire. This will enable us to perform a more comprehensive evaluation and to better meet your child's specific visual needs. Please bring toys or books your child enjoys.

~ Thank You ~