FOR PATIENT FILE USE ONLY

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

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

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

Home Address: _____
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.

Follow Up Care Form

Dear Parent / Guardian:

InfantSEE®, a public health program, managed by Optometry Cares® - the AOA Foundation, is designed to ensure that eye and vision care becomes an essential part of infant wellness care to improve a child's quality of life. Under this program, participating optometrists provide a one-time comprehensive infant eye assessment between 6 and 12 months of age as a no-cost public service.

If it is determined during the InfantSEE assessment that follow up care is needed for your child in the way of a comprehensive examination, treatment or therapy, you are free to choose any practitioner for these additional services. For a list of optometrists in your area, visit www.aoa.org or for additional information about the InfantSEE program call (888) 396-EYES (3937) or www.infantsee.org.

Thank you for choosing InfantSEE.

Infant Development during the First 12 Months

The first year of life is one of the most critical stages in childhood development. From the moment they open their eyes, newborns undergo dramatic physical and mental changes.

During the first 12 months, infants should be examined regularly to determine proper development and identify any health problems. Early detection and treatment of potential problems are vital to a child's development. The following developmental milestones should be monitored during routine well-care exams with the appropriate specialists.

	Vision	Speech & Hearing	Physical	Emotional & Social
By 3 Months	▪ Tends to see objects about a foot away ▪ Follows moving objects and reaches for things	▪ Sucks and swallows ▪ Quiets and smiles in response to sound or voice	▪ Pushes up on arms ▪ Lifts and holds head up	▪ Needs to be cradled and comforted ▪ Begins to develop trust in parents or caregivers
By 6 Months	▪ Eye movement and eye/body coordination skills develop ▪ Both eyes should focus equally	▪ Uses consonant sounds in babbling ▪ Uses babbling to get attention	▪ Uses hands to support self in sitting ▪ Rolls from back to tummy	▪ Smiles broadly and laughs when pleased ▪ Develops selfcalming skills to quiet down after being upset
By 9 Months	▪ Eye/body coordination skills develop further ▪ Eye contact begins to replace physical contact	▪ Increases variety of sounds and syllables ▪ Looks at familiar objects and people when named	▪ Sits and reaches for toys without falling ▪ Moves from tummy or back into sitting	▪ Gets angry and frustrated when their needs are not met ▪ Begins to fear strangers
By 12 Months	▪ Uses both eyes to judge distances	▪ Says "mama" and "dada"	▪ Pulls self up to stand ▪ Stands alone and takes independent step	▪ Expresses a variety of emotions such as fear, anger, dislike and happiness

Sources: *American Academy of Pediatrics, American Optometric Association – Your Baby's Eyes Brochure, Invest in Kids*