Pediatric Vision Development Center

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WELCOME TO PEDIATRIC VISION DEVELOPMENT CENTER

We look forward to meeting you at your appointment. Below are some helpful tips provided by InfantSEE program, in preparing for your appointment at the Pediatric Vision Development Center.

When setting an appointment time, let the practitioner know if you have any special concerns or conditions. Set an appointment time that is most agreeable to the baby's schedule, avoiding nap time.

On the day of the visit: Children in this age group generally perform best if the assessment takes place when they are alert. Because infants tend to be more cooperative and alert when feeding, it is also helpful to bring a bottle to feed the child, sunglasses if your child's eyes are dilated. Bring a security toy or object for the infant, but also toys or games that will hold older siblings' interest if they are coming too. If possible, arrange for only the infant and the parent to be present during the appointment.

During the assessment: Most eye exams will take about an hour and part of that time may include waiting for the dilation drops to take effect. You will most likely you will be asked to hold the baby on your lap, or on a lap pillow. Parents should be present for the assessment to help the baby focus on the doctor, so avoid talking to the baby or adults during the assessment. You may be recruited to hold targets or be a puppet master to hold the baby's attention during certain procedures. Be ready to play each "game" first to show the baby that it is safe and fun.

CANCELLED OR MISSED APPOINTMENTS: Please understand that each appointment time is dedicated to you and is therefore not available to anyone else. We understand emergencies occur, please notify us as soon as possible if you are unable to keep your appointment. If you have not cancelled your appointment and do not show, you are making this appointment time unavailable for others**.**

There is a $35.00 Fee for Not Showing for your appointment and/or Cancellations within 24 hours.

Name of Parent(s)_____ Email_____

Signature_____ Date_____

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.