

Vision Checklist

Please assist us in the screening by filling out both sides of this questionnaire.

Child's Name _____

Date of Birth _____ Age _____ Sex _____

Parent/Guardian Name _____ Phone _____

Address _____

Vision difficulties may be associated with the following observations or complaints:

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Eye crossed - turning in or out - at any time, or eyes do not appear straight, especially when the child is tired |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Redness in either eye that does not go away in several days. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Has continued pus or crust in either eye. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Has frequent sties. |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Eyes in constant motion. |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Eyelids droop. |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Complains of headache without illness. |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Complains of burning or itching of eyes. |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Complains of pain in the eyes. |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Light gazes or repeatedly flicks objects in front of face. |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Eyes are always sensitive to light. |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Eyes are always watery. |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Thrusts the head forward or backward while looking at distant objects. |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Turns or cocks the head to use one eye only. |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Tilts the head to one side. |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Places an object close to the eyes to look at it. |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Squints while looking at objects. |
| <input type="checkbox"/> | <input type="checkbox"/> | 18. Blinks eyes excessively. |
| <input type="checkbox"/> | <input type="checkbox"/> | 19. Has a tendency to rub eyes. |
| <input type="checkbox"/> | <input type="checkbox"/> | 20. Covers or closes one eye to see. |
| <input type="checkbox"/> | <input type="checkbox"/> | 21. Stumbles over objects. |
| <input type="checkbox"/> | <input type="checkbox"/> | 22. Lacks interest in looking at objects or seeing. |
| <input type="checkbox"/> | <input type="checkbox"/> | 23. Unable to see distant objects. |
| <input type="checkbox"/> | <input type="checkbox"/> | 24. Is unable to transfer an object from one hand to the other at midline. |
| <input type="checkbox"/> | <input type="checkbox"/> | 25. Is unable to stack blocks or other objects. |
| <input type="checkbox"/> | <input type="checkbox"/> | 26. There is a history of lazy eye or vision problems in family. |

Please remember to fill out the back side. →

Physical Development Checklist

- | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Did your child weigh less than 5 lbs. at birth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child had an illness with high fever? (104° longer than 2 days) |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child been hospitalized since birth for any reason?
If yes, state reason _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child take medication regularly?
If yes, what medication? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child have seasonal allergies?
If yes, how is it treated? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are your child's immunizations currently up to date?
If no, state reason _____ |

What can your child do well? _____

What things, if any, are difficult for your child? _____

Behavioral Checklist

- | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about your child's behavior?
If yes, describe behavior _____ |

Hearing Checklist

- | <u>Yes</u> | <u>No</u> | (Answer questions 1-7 for children under 2 years; answer questions 6-13 for children over 2 years) |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Turns his/her head toward an interesting sound or when his/her name is called. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Coos to himself/herself and makes noise when s/he is alone. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Uses his/her voice to get attention. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Tries to imitate you if you make child's own sound. |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Seems to have difficulty hearing. |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. There is a history of hearing problems in the family. |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Has had ear infections.
If yes, how many times and what was treatment _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Turns up T.V. louder than other members of the family. |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Seems to favor one ear over the other. |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Jumps or appears to be more startled than others if there is a sudden noise. |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Seems to hear you if you talk in a whisper. |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Makes you talk loudly or repeat frequently. |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Seems to speak as well as other children the same age. |

