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.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Andrea P. Thau and Associate *'s* Notice of Privacy Practices.

I further consent to the release of my health information for purposes of treatment, payment, and health care operations and as authorized by law under the circumstances described in the Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

If you are signing as a personal representative for the patient, describe your relationship to the patient and the source of your authority to sign the form:

Relationship to Patient:_____Print Name:_____

Source of Authority:_____