Child Vision History Questionnaire for Parent/Caregiver

Child's Name: _____ Age/DOB: _____

Parent/Caregiver Name: _____

Date Filled Out: _____

CHILD'S HISTORY: (Circle Yes or No as indicated)

Description	**Yes**	**No**
Do you suspect anything is wrong with your child's eye(s)/vision	Yes	No
Has your child ever been diagnosed with an eye condition	Yes	No
Have you observed any problems or change in the whites, pupils, lids, lashes, or the area around the eyes	Yes	No
Has your child shown any signs of abnormal sensitivity to light or dizziness	Yes	No
Has your child had any complaints of nausea or headaches	Yes	No
Turning of one eye (in, out, up, or down)	Yes	No
Poking at the eyes or frequent rubbing	Yes	No
Excessive blinking	Yes	No
Unusual watering or discharge of the eye(s)	Yes	No
Poor eye contact	Yes	No
Covering or closing an eye when looking at an item of interest	Yes	No
Abnormal head posture such as tilting the head to one side or moving forward or backward when viewing an item of interest	Yes	No
Squinting	Yes	No
Placing the head close to an item of interest	Yes	No
Inaccuracy in reaching for an item of interest	Yes	No
Was your child born before 32 weeks of age	Yes	No

Has any immediate family member(s) had eye/vision problems that required treatment at an early age (before age six years) such as amblyopia, or wearing glasses?
If yes, explain:

Do you have any concerns about your child's health in general or his/her ability to see clearly?
If yes, explain:

Has your child/ family member ever been diagnosed with any of the following conditions?

In the table below, circle yes or no for each condition, as indicated. If yes, write in the family member. Family member is defined as blood relatives: siblings/parents/grandparents/aunts/uncles.

Condition	**Yes**	**No**	**If Yes, who?**
Albinism	Yes	No	
Amblyopia	Yes	No	
Aniridia/Ankylosing Spondylitis	Yes	No	
Best Disease	Yes	No	
Coloboma	Yes	No	
Congenital cataract	Yes	No	
Congenital Glaucoma	Yes	No	
Diabetes Mellitus	Yes	No	
Trisomy 21 (also known as Down Syndrome)	Yes	No	
Fetal Alcohol Syndrome	Yes	No	
Juvenile Muscular Dystrophy	Yes	No	
Marfan Syndrome	Yes	No	
Myotonic Dystrophy	Yes	No	
Neurofibromatosis	Yes	No	
Optic Atrophy	Yes	No	
Pierre Robin Syndrome	Yes	No	

Prader-Willi Syndrome	Yes	No	
Retinoblastoma	Yes	No	
Retinitis Pigmentosa	Yes	No	
Rubella	Yes	No	
Sickle Cell Anemia	Yes	No	
Strabismus	Yes	No	
Sturge-Weber Disease	Yes	No	
Toxoplasmosis	Yes	No	
Turner Syndrome	Yes	No	
Usher Syndrome	Yes	No	
Wilson Disease	Yes	No	
Spondylo-Epiphyseal Dysplasia (SED) Congenita	Yes	No	
Kniest Syndrome (osteodysplasia)	Yes	No	
Bardet-Biedl Syndrome	Yes	No	
Idiopathic Carpotarsal Osteolysis, Francois Type (Also known as “Dystrophia Dermo-Chondro-Cornealis Familiaris”)	Yes	No	
Hallermann-Streiff-Francois Syndrome (Also known as “Francois Dyscephalic Syndrome” or “Oculo-Mandibulo Dyscrania with Hypotrichosis”)	Yes	No	
CHARGE Syndrome	Yes	No	
Rubinstein-Taybi Syndrome	Yes	No	
Stickler Syndrome	Yes	No	
Nystagmus	Yes	No	
Vision loss/blindness	Yes	No	

Maternal Child Health section
85 E 7th Place
St. Paul, MN 55164-0882
651-201-3760
health.childteencheckups@state.mn.us
www.health.state.mn.us

Reviewed 7/01/2018

To obtain this information in a different format, call: 651-201-3760.