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.

InfantSEE® Clinical Reporting Form

http://exam.infantsee.org

Date of Exam ____/____/____

Gender: ☐ M ☐ F **Date of Birth** ____/____/____ **Age** (in Months):____

Patient City____ **State**____ **Zip** ____

Birth History: Born Premature? ☐ Yes ☐ No If yes: born at how many weeks premature____

Delivery Complications: ____

Ethnic Origin: ☐ Hispanic ☐ Caucasian ☐ African American ☐ Native American ☐ Asian ☐ Other

Insurance: ☐ Yes ☐ No If yes: ☐ Private ☐ CHIP ☐ Medicaid ☐ Other, specify____

How did you find out about InfantSEE®?

☐ Current Patient
☐ Friend/Family
☐ Mail
☐ TV
☐ Radio
☐ Internet
☐ Newspaper
☐ Primary Health Provider
☐ Parenting Classes
☐ Other, specify ____

Yearly Household Income: (Required for HRSA Grant States Only)

☐ Less than $20,000
☐ $20,000-$39,999
☐ $40,000-$59,999
☐ $60,000-$79,999
☐ $80,000-$99,999
☐ More than $100,000

Medical History ____

ASSESSMENT (Use InfantSEE® Clinical Assessment Criteria)

Ocular Motility	☐ No Concern	☐ Concern	☐ Problem ____
Binocularity	☐ No Concern	☐ Concern	☐ Problem ____
Refractive Status	☐ No Concern	☐ Concern	☐ Problem ____
Visual Acuity	☐ No Concern	☐ Concern	☐ Problem ____
Ocular Health	☐ No Concern	☐ Problem ____	
Dilation	☐ Yes	☐ No	

Plan
☐ No Concerns
☐ Concerns and in need of follow up care in _____ months or _____ weeks

Referral to:____

Recommended follow-up: _____ years of age

OD Name/AOA Number	State	Zip Code	Date

If unable to enter online, mail to: 243 N. Lindbergh Blvd., St. Louis, MO 63141 or fax to: (314) 991-4101
For questions Call: (800) 365-2219, ext. 4286 or write to: infantsee@aoa.org

InfantSEE® Clinical Assessment Form

http://exam.infantsee.org

Date of Exam ____/____/____

FOR PATIENT FILE USE ONLY

Infant Name: _____ **D.O.B.:** ____/____/____ **Age:** _____ Months

Parent/Guardian: _____ **Premature?** Yes ☐ No ☐ If yes: how many weeks _____

Gender: ☐ Male ☐ Female **Ethnic Origin:** ☐ Hispanic ☐ Caucasian ☐ African American ☐ Native American ☐ Asian ☐ Other

Reason for Visit:
☐ Requested InfantSEE® Assessment
☐ Referred; reported problem: _____

How did you find out about InfantSEE®?
☐ Current patients ☐ Friend/family ☐ Mail / print ads ☐ TV
☐ Radio ads ☐ Internet ☐ Newspaper
☐ Primary health provider ☐ Parenting classes
☐ Other, specify _____

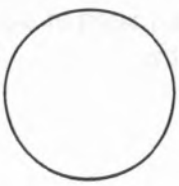
Visual Acuity:
Fix & Follow Method: OD ☐ Y ☐ N OS ☐ Y ☐ N
Resistance to Occlusion: OD ☐ OS ☐ ☐ None
10 Vertical Prism Test: ☐ Pass ☐ Fail
OD _____ OS _____ OU _____ ☐ Teller ☐ Richman

Ocular Motility: ☐ Full Range of Motion (FROM) ☐ Motility Limitation: _____

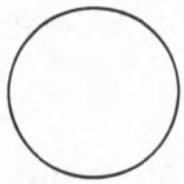
Alignment / Binocular Potential:
Hirschberg: ☐ Aligned ☐ Misaligned _____
Cover Test: ☐ Normal Alignment ☐ Strabismus: _____
☐ Phoria: _____
Convergence Estimate: ☐ Normal ☐ Inadequate
10 Vertical Prism Test: ☐ Pass ☐ Fail
Brückner ☐ Equal reflexes Whiter and Brighter: ☐ R ☐ L

Refractive Status:
Manifest Retinoscopy OD _____ _____ _____
OS _____ _____ _____
Additional Retinoscopy OD _____ _____ _____
OS _____ _____ _____
☐ Mohindra ☐ Cycloplegic: Agent: _____

External/Anterior Segment Evaluation: ☐ Normal Problem Noted: _____
Visual Field Assessment: ☐ Full OU ☐ Full OD ☐ Full OS Problem Noted: _____
Pupil Evaluation: ☐ Normal Problem Noted: _____



Internal Assessment
CL Lens CL
CL Vitreous CL
_____ Disc _____
_____ Vessels _____
CL Macula CL
\+ Foveal Reflex +
_____ Peripheral Retina _____



☐ dilated ☐ non-dilated

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Plan	☐ No Concerns	☐ Concerns and in need of follow up care in _____ months or _____ weeks	

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OD Name/AOA Number	State	Zip Code	Date

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