Stillwater
AREA PUBLIC SCHOOLS

EARLY CHILDHOOD FAMILY CENTER
1111 Holcombe Street S. | Stillwater, Minnesota 55082
Tel: 651.351.4000 | fax: 651.351.4053
www.stillwaterschools.org

Child Vision History Questionnaire for Parent/Caregiver

Child Name ____ **DOB** ______________________________

Parent/Caregiver Name: ____ **Today's date** _________________

Child's History : (Check 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 areas 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 eyes?	**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 the age of six) such as amblyopia , or wearing glasses ? ____________________________
If yes, please explain? ____

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Child Hearing History Questionnaire for Parent/Guardian

Child's name: ____ DOB ________________________

Child's History (Check YES or NO as indicated)

Description	Yes	No
Caregiver concern regarding hearing, speech, language and development delay?	Yes	No
Family history of permanent childhood hearing loss?	Yes	No
Neonatal intensive care for more than 5 days?	Yes	No
In utero infections such as CMV, herpes, rubella, syphilis and toxoplasmosis?	Yes	No
Craniofacial anomalies?	Yes	No
Postnatal infections associated with sensorineural hearing loss including confirmed bacterial and viral (especially herpes virus and varicella meningitis) ?	Yes	No
Head trauma especially basal skull or temporal bone fracture that required hospitalization?	Yes	No
Chemotherapy?	Yes	No
Tugs at ears?	Yes	No
Turns side of head towards speakers?	Yes	No
Watches speaker's lips?	Yes	No
Talks too loudly or softly?	Yes	No
Has a speech problem?	Yes	No