Child's Vision and Hearing History Additional Questionnaire for Parent/Guardian

Child's Name_____

Parent/Guardian Name_____

Date Completed_____

Vision Questions: Does/Has your child…have you noticed…

Description	**Yes**	**No**
Suspect anything is wrong with your child's eye(s)/vision		
Been diagnosed with an eye condition		
Observed any problems or change in the whites, pupils, lids, lashes, or the area around the eyes		
Shown any signs of abnormal sensitivity to light or dizziness		
Complained of nausea or headaches		
Turning of one eye (in, out, up, or down)		
Poke at the eyes or frequently rubs eyes		
Blink excessively		
Unusual watering or discharge of the eye(s)		
Poor eye contact		
Covering or closing an eye when looking at an item of interest		
Abnormal head posture such as tilting the head to one side or moving forward or backward when viewing an item of interest		
Squinting		
Placing the head close to an item of interest		
Inaccuracy in reaching for an item of interest		
Child born before 32 weeks of age		
Any immediate family members had eye/vision problems that required treatment at an early age (before age six) such as wearing glasses, or amblyopia		

Hearing Questions: Does your child…

Description	**Yes**	**No**
Complain about fullness, noise, or pain in the ear		
Have drainage from the ear		
Complain about not hearing		
Tug at the ear(s)		
Is inattentive to conversation, asks/needs to have things repeated		
Watch the speaker's lips		
Show strain when listening		
Speak too loudly or too softly		
Have any speech difficulties		
Have any family history of permanent childhood hearing loss		