



FOR PATIENT FILE USE ONLY

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
_____ Illness _____ Age at the time. Was the illness? [] Mild [] Moderate [] Severe
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.
Parent/Guardian Signature _____ Date: ___/___/___
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.



Follow Up Care Form

Dear Parent / Guardian:

InfantSEE®, a public health program, managed by Optometry Cares® - the AOA Foundation, is designed to ensure that eye and vision care becomes an essential part of infant wellness care to improve a child's quality of life. Under this program, participating optometrists provide a one-time comprehensive infant eye assessment between 6 and 12 months of age as a no-cost public service.

If it is determined during the InfantSEE assessment that follow up care is needed for your child in the way of a comprehensive examination, treatment or therapy, you are free to choose any practitioner for these additional services. For a list of optometrists in your area, visit www.aoa.org or for additional information about the InfantSEE program call (888) 396-EYES (3937) or www.infantsee.org.

Thank you for choosing InfantSEE.

Infant Development during the First 12 Months

The first year of life is one of the most critical stages in childhood development. From the moment they open their eyes, newborns undergo dramatic physical and mental changes.

During the first 12 months, infants should be examined regularly to determine proper development and identify any health problems. Early detection and treatment of potential problems are vital to a child's development. The following developmental milestones should be monitored during routine well-care exams with the appropriate specialists.

	Vision	Speech & Hearing	Physical	Emotional & Social
By 3 Months	<ul style="list-style-type: none"> ▪ Tends to see objects about a foot away ▪ Follows moving objects and reaches for things 	<ul style="list-style-type: none"> ▪ Sucks and swallows ▪ Quiets and smiles in response to sound or voice 	<ul style="list-style-type: none"> ▪ Pushes up on arms ▪ Lifts and holds head up 	<ul style="list-style-type: none"> ▪ Needs to be cradled and comforted ▪ Begins to develop trust in parents or caregivers
By 6 Months	<ul style="list-style-type: none"> ▪ Eye movement and eye/body coordination skills develop ▪ Both eyes should focus equally 	<ul style="list-style-type: none"> ▪ Uses consonant sounds in babbling ▪ Uses babbling to get attention 	<ul style="list-style-type: none"> ▪ Uses hands to support self in sitting ▪ Rolls from back to tummy 	<ul style="list-style-type: none"> ▪ Smiles broadly and laughs when pleased ▪ Develops self-calming skills to quiet down after being upset
By 9 Months	<ul style="list-style-type: none"> ▪ Eye/body coordination skills develop further ▪ Eye contact begins to replace physical contact 	<ul style="list-style-type: none"> ▪ Increases variety of sounds and syllables ▪ Looks at familiar objects and people when named 	<ul style="list-style-type: none"> ▪ Sits and reaches for toys without falling ▪ Moves from tummy or back into sitting 	<ul style="list-style-type: none"> ▪ Gets angry and frustrated when their needs are not met ▪ Begins to fear strangers
By 12 Months	<ul style="list-style-type: none"> ▪ Uses both eyes to judge distances 	<ul style="list-style-type: none"> ▪ Says "mama" and "dada" 	<ul style="list-style-type: none"> ▪ Pulls self up to stand ▪ Stands alone and takes independent step 	<ul style="list-style-type: none"> ▪ Expresses a variety of emotions such as fear, anger, dislike and happiness

Sources: American Academy of Pediatrics, American Optometric Association – Your Baby's Eyes Brochure, Invest in Kids



Clinical Reporting Form (Long)

Assessment Date: ___/___/___

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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 OD _____ Additional OD _____
Retinoscopy OS _____ Retinoscopy OS _____

Mohindra Cycloplegic: Agent: _____

External/Anterior Segment Evaluation:

Normal Problem Noted: _____

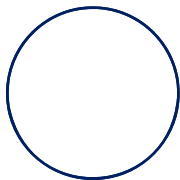
Visual Field Assessment:

Full OU Full OD Full OS Problem Noted: _____

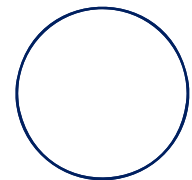
Pupil Evaluation:

Normal Problem Noted: _____

Internal Assessment



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



dilated non-dilated

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 _____

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

Referral to: _____ Recommended follow-up: _____ years of age

Table with 4 columns: OD Name/AOA Number, State, Zip Code, Date



Ocular Motility

- No Concern – ability to look at the target, follow and maintain for a brief period or until something else captures the attention
- Concern – Reduced ability to gain visual attention in the primary position
- Problem - Any limitation of movement in the cardinal meridian

Binocularity (Cover Test Data)

- No Concern – stereo response on gross targets
- Concern – no response on stereo targets
- Problem – obvious or subtle strabismus

Refractive Status

1. Hyperopia

- No Concern – Less than +3.50 - discuss risk, what to watch for, and usually seen at age 3
- Concern – Between +3.50 and +5.00 - definite need to follow up within 6 to 12 months
- Problem – Over +5.00 - establish patient in an optometric office

2. Myopia

- No Concern - Less than -1.00 - discuss risk, what to watch for, and usually seen at age 3
- Concern – Slightly over -1.00 definite need to follow up within 6 to 12 months
- Problem – Well over -1.00 - establish patient in an optometric office

3. Astigmatism

- No Concern – Less than 2.00 - discuss risk, what to watch for, and usually seen at age 3
- Concern – 2.00 to 3.00 - Definite need to follow up within 6 to 12 months
- Problem – 3.00 – over 3.00 - Establish patient in an optometric office

4. Anisometropia

- No Concern – Less than 1.00 - discuss risk, what to watch for, and usually seen at age 3
- Concern – Between 1.00 and 2.00 - definite need to follow up within 6 to 12 months
- Problem – Over 2.00 - establish patient in an optometric office

Visual Acuity / Looking Behavior

- No Concern
- Concern – Reduced ability to look/fixate
- Problem – Fixation preference for one eye or Failed Visual Acuity test

Ocular Health

- No Concern
- Problem – any noted anomaly