



Vision and Hearing Questionnaire (Eye and Ear History)

Child's Name: _____ Sex: _____ Age: _____ Date of Birth: _____

Mother's Name: _____ Father's Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Secondary Phone Number: _____

General Information

1. Did your child weigh less than 5 ½ pounds at birth? Yes No
2. Was there a problem with breathing at birth? Yes No
3. Did your child have yellow jaundice at birth? Yes No
4. Had your child ever had a head injury? Yes No
5. Did the child's mother have German measles (3 day) during pregnancy? Yes No
6. Please list the names of younger children in the family:

Family Eye History

1. Has your child ever been seen by an eye doctor? Yes No

If YES, please explain:

2. Does your child wear eyeglasses? Yes No
3. Have you noticed signs which might indicate eye difficulty? Yes No
4. Do the child's eyes look crossed, particularly when tired or ill? Yes No
5. Do any of the child's family members have a crossed eye?
Mother Father Sister/Brother Grandparent
6. Has the child ever had an eye surgery? Yes No
7. Do any of the child's family members have an eye that is much weaker than the other?
Mother Father Sister/Brother Grandparent

Family Ear History

1. Do any of the child's family members have a hearing loss?
Mother Father Sister/Brother Grandparent
2. Has your child ever had a hearing test? Yes No
3. Has your child ever had ear infections, earaches, or ear drainage? Yes No
4. Does your child have allergies? Yes No
5. Have your child's tonsils and adenoids been removed? Yes No
6. Has your child ever had ear tubes surgically placed? Yes No
7. Does your child have a hearing loss? Yes No

Form continued on the back!



Name of Primary Care Physician: _____

Name of (Eye Doctor) <If applicable>: _____

Name of Ear, Nose, and Throat Doctor (ENT) <If Applicable>: _____

Please describe any additional concerns or information about your child's hearing or vision:

Screening Results

(Office Use Only)

Hearing 1: P F **Attempt 2:** P F Could not test

Vision 1: P F **Attempt 2:** P F Could not test

Referred for a medical hearing evaluation? Yes No

Referred for a medical vision evaluation? Yes No

Additional Comments: