**Sarah Kuhlemeier**
Early Learning Academy
Program Coordinator

Early Learning Academy

# 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 and 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!***

**Regional Office of Education #08**
**27 S. State Ave., Suite 101, Freeport, IL 61032**
**Phone: 815.599.1408 Fax: 815.297.9032**
**www.roe8.com**

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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 **2:** _____P _____F _____R _____CNT _____FNR

**Vision 1:** _____P _____F **2:** _____P _____F _____R _____CNT _____FNR

Referred for a medical hearing evaluation? _____Yes _____ No

Referred for a medical vision evaluation? _____Yes _____ No

Additional Comments:

_____

_____

_____

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