



405 S. 30th Street

Corner of 30th and Garfield

Laramie, WY 82070

Infant/Developmental Questionnaire

Name _____ Date _____

Parental Name(s) _____

Address _____ Phone _____

Date of Birth _____ Age _____ Gender M F

1. Reason for visit:
___ eye turns in ___ eye turns out
___ squinting ___ doesn't see things
___ rubs eyes a lot ___ general check up
___ other (please specify) _____

2. Mother's age when child was born. _____

3: Length of pregnancy. _____

4. Any complications with pregnancy? Yes No
please specify _____

5. Any medications taken during pregnancy? Yes No
please specify _____

6. Labor: ___ was ___ was not induced.

7. Labor lasted for ___ hours.

8. Delivery was: ___ natural ___ caesarian
___ anesthetic ___ forceps

9. Any complication with delivery? Yes No
please specify _____

10. Child's birth weight. _____

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11. Do you know your child's apgar score? Yes No
 please specify _____

12. Any complications with development following birth? Yes No
 please specify _____

Developmental Stages

Activity	Ave. Age	Early	Late	Normal	Unsure
Eye Control	4 weeks	_____	_____	_____	_____
Head Balance	16 weeks	_____	_____	_____	_____
Hand Grasp/Manipulation	28 weeks	_____	_____	_____	_____
Sits, Creeps	40 weeks	_____	_____	_____	_____
Stands	12 months	_____	_____	_____	_____
Walks	18 months	_____	_____	_____	_____
Uses Words/Phrases	20 months	_____	_____	_____	_____
Bladder/ Bowel control	2 years	_____	_____	_____	_____
Uses sentences	3 years	_____	_____	_____	_____
Understands numbers	4 years	_____	_____	_____	_____

Has rate of learning been : fast average slow

Family History: Please check all that might apply.

	Near-Sighted	Far-Sighted	Astigmatism	Lazy Eye	Turned Eye
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____

Child's Pediatrician: _____

Parent's Signature _____ Date _____