A Shared Vision
Partners in Pediatric Blindness & Visual Impairment

Vision Screening Parent Questionnaire for Children Birth to Age Three

This questionnaire will help gather valuable information about your child's vision. If there are possible vision concerns, we will discuss these with you and whether a visit to a vision professional is needed. This form should be completed by the person who knows your child and family medical history the best. **Please return the completed questionnaire to the email address provided at the end of the document prior to your Early Intervention Evaluation meeting.** If you cannot email the completed questionnaire, please bring it with you to your scheduled meeting.

Child's Name:		Child's DOB	
Caregiver's Name:		Today's Date:	
Organization:			
Contact Person:		Contact Person's Email:	

Family Vision History (Parents and Siblings)

Is there family history of eye crossing (strabismus) or vision loss due to eye crossing (amblyopia) – grandparent, parents, siblings?	Yes ☐	No ☐
Did anyone in your family need prescription glasses before age 6 years?	Yes ☐	No ☐
Please describe any other family vision problems (e.g., retinoblastoma, born with cataracts or glaucoma, etc.).		

Child's Medical History

Has your child been affected by or diagnosed with any of the following? Leave blank if you are unsure or don't know.

Prematurity (i.e., born before 32 weeks).	Yes ☐	No ☐
Birth weight less than 4.5 pounds.	Yes ☐	No ☐
Needed oxygen more than 4 days as a newborn.	Yes ☐	No ☐
Hearing loss.	Yes ☐	No ☐
Head or facial differences at birth (e.g., cleft lip/palate, craniosynostosis, etc.).	Yes ☐	No ☐
Prenatal exposure to infections (e.g., CMV, syphilis, rubella, toxoplasmosis, etc.).	Yes ☐	No ☐
Meningitis or encephalitis.	Yes ☐	No ☐
Prenatal exposure to drugs or alcohol.	Yes ☐	No ☐
Any type of syndrome (e.g., Down Syndrome, CHARGE Syndrome, etc.).	Yes ☐	No ☐
Brain injury (e.g., lack of oxygen, stroke, accidental or non-accidental trauma, etc.).	Yes ☐	No ☐
Neurological conditions (e.g., cerebral palsy, infantile spasms or other seizure disorders, hydrocephalus, etc.).	Yes ☐	No ☐
Delayed Visual Maturation or Cortical/Cerebral Visual Impairment (CVI).	Yes ☐	No ☐

Eye Doctor Examination

Has an eye doctor examined your child's eyes?	Yes ☐	No ☐
If yes, when was the most recent exam (month, year)?		
What were the results of the exam?		
Were eyeglasses or another treatment prescribed?	Yes ☐	No ☐
If the doctor prescribed eyeglasses, does your child wear them?	Yes ☐	No ☐
If your child does not wear their glasses, what is the reason?		

We can learn a lot about the health of your child's vision by looking at the appearance of their eyes and eyelids, observing their visual behaviors, and listening to your concerns about your child's vision.

Appearance of Eyes and Eyelids

Please take a few moments to look at your child's eyes and eyelids. Answer yes or no to the following questions. If you are unsure, leave the question blank.

Does one eye look different than the other eye? For example, one eye looks much smaller, or one eye is higher on the face than the other eye.	Yes ☐	No ☐
Do one or both eyes turn in, out, up, or down? This may happen all of the time or only some of the time.	Yes ☐	No ☐
Is there a difference in the black color, size, or shape of the pupils in one or both eyes? The pupil is the dark black center of each eye.	Yes ☐	No ☐
Is there a difference in the size and shape of the iris in one or both eyes? The iris is the colored part of each eye.	Yes ☐	No ☐
Do one or both of their eyes appear white or cloudy?	Yes ☐	No ☐
Do their eyes involuntarily move or rapidly move – dancing/ jiggling up and down or side to side?	Yes ☐	No ☐
Are their eye(s) red and/or excessively mattered beyond the usual sleep matter when the child first awakens or due to allergies?	Yes ☐	No ☐
Are their eyelids red, swollen, and/or encrusted?	Yes ☐	No ☐
Does one eyelid droop or appear lower than the other?	Yes ☐	No ☐

If you answered "yes" to any of the questions above, when did you first notice it? Did this happen suddenly? Please describe.

Behaviors

Your child's actions may indicate that something may not be right with their vision. Please think about how your child uses their vision during the day. Answer yes or no to the statements below. If you are unsure, leave the statement blank.

My child…

Answer the following statement for children one month or older

1. Has difficulty looking at and making eye contact with me for at least 3 seconds.	Yes ☐	No ☐

And answer the following statements for children three months or older

2. Tilts or turns their head to the side, lifts or lowers their chin, and/or thrusts their head forward or backward when looking at something at near or far range. Circle which behavior you notice.	Yes ☐	No ☐
3. Holds an object very close to their eyes (within 1-4 inches) when looking at it.	Yes ☐	No ☐
4. Has trouble seeing small objects such as a piece of lint, or a small piece of cereal left on a tray or table.	Yes ☐	No ☐
5. Frowns, squints, or covers an eye when looking at something at near or far distance.	Yes ☐	No ☐

6. Appears to be looking over, under, or beside people or objects rather than looking straight at them.	Yes ☐	No ☐
7. Shows more interest in looking at overhead lights or windows than looking at people or toys.	Yes ☐	No ☐
8. Struggles to recognize familiar people before hearing their voices.	Yes ☐	No ☐
9. Recognizes a familiar toy only after touching or hearing it.	Yes ☐	No ☐
10. Only sees an object when it is separated from other items. For example, cannot find a specific toy when it is among other objects.	Yes ☐	No ☐
11. Notices people, pets, or objects only when they are moving.	Yes ☐	No ☐
12. Looks away when reaching toward a nearby object.	Yes ☐	No ☐
13. Reaches over or under something when they are trying to grasp it.	Yes ☐	No ☐

And answer the following statements for children who are 12 months or older

14. Has difficulty detecting a change in a floor surface, such as from tile to carpet.	Yes ☐	No ☐
15. Frequently stumbles over objects or bumps into things that are in their path. Hesitates or misses detecting a step or a curb.	Yes ☐	No ☐
16. Avoids looking at or pointing to pictures in books or on a screen.	Yes ☐	No ☐
17. Has a hard time finding small details in pictures (e.g., when asked to point to a dog's nose).	Yes ☐	No ☐
18. Has difficulty seeing or pointing to something over 20 feet away, such as a dog across the street, an airplane flying overhead.	Yes ☐	No ☐

Caregiver Concerns

Do you have any concerns about your child's vision that were not addressed in the earlier questions? If yes, please describe.

Next Steps:

Please return this questionnaire to the email address below prior to your evaluation or meeting. If you cannot email the completed questionnaire, please bring it with you to your meeting.

To Be Completed by Vision Screening Professional – when was Parent Questionnaire completed?

☐ EI Evaluation ☐ IFSP (initial, annual, periodic review) ☐ Other

References:

Colorado Department of Education (2005). *Visual Screening Guidelines: Children Birth through Five Years.*

Teach CVI (2020). *Screening List for Children with a Suspicions of a Cerebral Visual Impairment (CVI) / Screen List CVI 1.* Click HERE for the document.

Topor, I. (2004). *Approximate functional visual acuity for different sizes of objects and distances*. Chapel Hill, NC: Early Intervention Training Center for Infants and Toddlers with Visual Impairments, FPG Child Development Institute, UNC-CH.