

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:	
Community Centered Board:			
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 <input type="checkbox"/>	No <input type="checkbox"/>
Did anyone in your family need prescription glasses before age 6 years?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
Birth weight less than 4.5 pounds.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Needed oxygen more than 4 days as a newborn.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hearing loss.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Head or facial differences at birth (e.g., cleft lip/palate, craniosynostosis, etc.).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Prenatal exposure to infections (e.g., CMV, syphilis, rubella, toxoplasmosis, etc.).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Meningitis or encephalitis.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Prenatal exposure to drugs or alcohol.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any type of syndrome (e.g., Down Syndrome, CHARGE Syndrome, etc.).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Brain injury (e.g., lack of oxygen, stroke, accidental or non-accidental trauma, etc.).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Neurological conditions (e.g., cerebral palsy, infantile spasms or other seizure disorders, hydrocephalus, etc.).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Delayed Visual Maturation or Cortical/Cerebral Visual Impairment (CVI).	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Eye Doctor Examination

Has an eye doctor examined your child's eyes?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, when was the most recent exam (month, year)?		
What were the results of the exam?		
Were eyeglasses or another treatment prescribed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If the doctor prescribed eyeglasses, does your child wear them?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
Do one or both of their eyes appear white or cloudy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do their eyes involuntarily move or rapidly move – dancing/ jiggling up and down or side to side?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are their eye(s) red and/or excessively mattered beyond the usual sleep matter when the child first awakens or due to allergies?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are their eyelids red, swollen, and/or encrusted?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does one eyelid droop or appear lower than the other?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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 <input type="checkbox"/>	No <input type="checkbox"/>
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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 <input type="checkbox"/>	No <input type="checkbox"/>
3. Holds an object very close to their eyes (within 1-4 inches) when looking at it.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
5. Frowns, squints, or covers an eye when looking at something at near or far distance.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

6. Appears to be looking over, under, or beside people or objects rather than looking straight at them.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Shows more interest in looking at overhead lights or windows than looking at people or toys.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8. Struggles to recognize familiar people before hearing their voices.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9. Recognizes a familiar toy only after touching or hearing it.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
11. Notices people, pets, or objects only when they are moving.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12. Looks away when reaching toward a nearby object.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13. Reaches over or under something when they are trying to grasp it.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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

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 Early Intervention Evaluation. If you cannot email the completed questionnaire, please bring it with you to your scheduled Early Intervention Evaluation.

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 Suspicion 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.