Colin V. Connors, O.D.
Richard M. Jun, O.D.
Aja L. Kimrey, O.D.
Callie M.P. Maursetter, O.D.
Timothy N. Wilson, O.D.

Isthmus Eye Care InfantSEE Form

Today's Date: _____ / _____ / _____

Infant's Name: _____
Date of Birth: _____ / _____ / _____
Address: _____
_____

Parent/Guardian: _____
Home: (_____) _____
Work: (_____) _____
Cell: (_____) _____

How did you find out about the InfantSEE program?
□ Friend/Family: _____ □ Health Care Provider/Doctor □ Internet/Website □ Other

EYE HISTORY

Have you ever noticed any of the following happening with your baby's eyes?
- □ Turn in
- □ Turn out
- □ Watering
- □ Have swelling
- □ White appearance in pupil

Explain any eye concerns noted by observing your baby: _____
_____

DEVELOPMENTAL AND HEALTH HISTORY

Pregnancy
Length of pregnancy:
- □ 36 weeks or more
- □ Less than 36 weeks; number of weeks: _____

Pregnancy complications?
- □ Uncomplicated
- □ Mother's complications; please explain: _____
- □ Baby's complications; please explain: _____

Delivery
Birth weight: _____
Delivery complications?
- □ Yes; please explain: _____
- □ No

Over ➲

Development

Check all of the following that your baby can do at this time:

- □ **Roll over**
- □ **Sit**
- □ **Crawl**
- □ **Stand**
- □ **Walk**

List any complications of development: _____

_____

MEDICAL HISTORY INFORMATION

Baby's doctor: _____

Last exam date: _____

Are immunizations up to date?

- □ **Yes**
- □ **No**

Does your baby have any known food or drug allergies?

- □ **Yes; please list: _____**
- □ **No**

List ALL medications taken regularly: _____

_____

Please list any childhood illnesses your baby has had and the age they occurred: _____

_____

_____

Please list any accidents, eye or head injuries and the age they occurred: _____

_____

_____

Please list any family members with a history of eye or medical problems: _____

_____

_____

Thank you for carefully completing this confidential questionnaire. This information will allow for a more efficient use of examination time and will contribute to the understanding of eye and vision development.

I understand the above information is necessary to provide my baby with ocular and vision care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. With my approval, I authorize the doctor to perform diagnostic procedures and treatments as may be necessary for proper ocular and vision care.

Parent's Signature:_____ Date: _____/_____/_____

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ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received the chance to review a copy of the Isthmus Eye Care, S.C. Notice of Privacy Practices.

Patient Name____

Parent's Signature___________________________________ Date____________

I give consent to the release of any or all of my Isthmus Eye Care records to the following persons listed below that may need access to them.*

*Consent in place until revoked from patient

Name______________________________ Relation to patient______________ Date__________

Name______________________________ Relation to patient______________ Date__________

Name______________________________ Relation to patient______________ Date__________

~ ~

I check this box to give consent to the release of any or all of my Isthmus Eye Care records through the online "Personal Health Records" portal to the following persons listed below that may need access to them and are current patients at Isthmus Eye Care.*

*Consent in place until revoked from patient

□ All family members that are patients at Isthmus Eye Care

□ Name: ____ Date___________

□ Name: ____ Date___________

□ Name: ____ Date___________

□ Do not link my Personal Health Records/Withdrawal Consent

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