VISION AND HEARING SCREENING QUESTIONNAIRE

CHILD'S NAME: _____ DOB: _____

DATE: _____ GENDER: M / F

VISUAL CONSIDERATIONS:

1.	Does the child have an eye that turns up, down, in or out independently of the movement of his/her other eye?.....	YES	NO
2.	Can the child follow with his/her eyes a moving target held approximately ten or twelve inches in front of him/her?.....	YES	NO
3.	When following a moving target with his/her eyes, can he/she easily move his/her eyes past his/her body midline?.....	YES	NO
4.	Does the child blink excessively?	YES	NO
5.	Does he/she rub his/her eyes frequently? ……...	YES	NO
6.	Does the child turn his/her head to favor one eye when looking at something? ……	YES	NO
7.	Does he/she close or cover one eye frequently? …….	YES	NO
8.	Does the child frequently hold things very close to his/her face to see them? ……...	YES	NO
9.	Are you concerned with his/her vision? …….	YES	NO

If so why? _____

_____

VISION: PASS FAIL ___ May want to consider follow-up with Pediatrician

HEARING CONSIDERATIONS:

1.	Does child look when name is called, if he/she is not already looking at the caller? ……	YES	NO
2.	Does the child respond when given simple directions? ……	YES	NO
3.	Does he/she react to loud or unexpected loud noises? (flinch? Or Cover his/her ears?) ……..….	YES	NO
4.	Does the child say any words clearly? (Examples: mama, dada, yes, no, etc.)……	YES	NO
5.	Does the child notice and/or imitate environmental sounds, such as a dog barking or a plane overhead? ……..	YES	NO
6.	Is there a medical history of infections, tubes, wax buildup etc.? ……..	YES	NO
7.	Are you concerned with his/her hearing? ……..	YES	NO

If so why? _____

_____

HEARING: PASS FAIL ___ May want to consider follow-up with Pediatrician

ADDITIONAL COMMENTS: _____

_____

_____

_____ _____

Interviewer Signature/Title Parent Signature