



Health, Hearing & Vision Assessment

HEALTH ASSESSMENT		Date:	By:	RN
		Records Review Date:	By:	RN
Child's Name <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth		
		Age	months	
		Gestation	weeks	
Parent/Guardian		Phone		
Primary Care Physician		Phone		
Other Consulting Medical Professional		Phone		
Other Consulting Medical Professional		Phone		

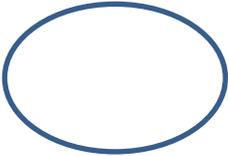
Prenatal/Birth History	Child Medical History	Family Medical History
Routine prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Significant illnesses	<input type="checkbox"/> Learning delays
Prenatal exposure to alcohol, smoking, medications, or toxic substances? <input type="checkbox"/> Yes <input type="checkbox"/> No List:	<input type="checkbox"/> Hospitalizations	<input type="checkbox"/> Developmental delays
At birth, child health was: <input type="checkbox"/> Stable <input type="checkbox"/> Unstable Describe:	<input type="checkbox"/> Injuries	<input type="checkbox"/> Mental health concerns
If premature: <input type="checkbox"/> Oxygen: # days _____ <input type="checkbox"/> IVH <input type="checkbox"/> ECMO <input type="checkbox"/> ROP <input type="checkbox"/> Ventilator: # days _____	<input type="checkbox"/> Surgeries	Describe:
	<input type="checkbox"/> Seizures	
	<input type="checkbox"/> TBI	
	Describe:	

Medical Diagnoses	Date	Medications/Supplements	Parent Concerns about Child's Health
1.		1.	Does either parent have a family history of Autism? <input type="checkbox"/> Yes <input type="checkbox"/> No
2.		2.	Are you or anyone who knows your child concerned about Autism, or do you have any other concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No
3.		3.	
4.		4.	
5.		5.	

Feeding/Nutrition	<input type="checkbox"/> Receives WIC services
<input type="checkbox"/> NG/NJ/GT feeds: times/day _____	Concerns about child's weight gain? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bottle/breast feeds: times/day _____	Does child have reflux? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cereal <input type="checkbox"/> Fruit <input type="checkbox"/> Veggies <input type="checkbox"/> Meat	Is child on a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Table foods <input type="checkbox"/> Textured foods	If so, what kind of diet?
<input type="checkbox"/> Finger feeds <input type="checkbox"/> Spoon feeds	Does child have difficulty chewing/swallowing? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Drinks from cup <input type="checkbox"/> Sippy cup	If so, what food types?
<input type="checkbox"/> Vitamin D if breast fed	Other feeding/nutrition concerns?

HEARING ASSESSMENT		Date:	By:
Newborn hearing screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Describe:	Facial Features: <input type="checkbox"/> Ear tags/pits <input type="checkbox"/> Low, lopsided atypical ears <input type="checkbox"/> Cleft lip and/or palate <input type="checkbox"/> Irregularly spaced eyes/ears
If Fail, follow up?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
CMV test results?	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not completed		
History of ear infections?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How many?	
History of ear tubes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dates:	
Fam history of childhood HL?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:	
Concerns about child's hearing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:	

Hearing Summary		<input type="checkbox"/> PASS	<input type="checkbox"/> REFER	<input type="checkbox"/> REFER TO USDB-PIP	<input type="checkbox"/> INCONCLUSIVE
Assessment	Date	Right Ear		Left Ear	
Audiological exam		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
OAE		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
Tympanogram		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail

VISION ASSESSMENT		Date:	By:	RN
Eye Appearance (indicate R, L, or B for all that apply)		Misalignment (do not test under 3 months adjusted age)		
Tracking:	R / L / B	Misalignment Observed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fixates:	R / L / B		<input type="checkbox"/> With glasses <input type="checkbox"/> Without glasses	
No pupil response to light:	R / L / B	If misalignment noticeable, draw where eyes usually rest.		
Excessive sensitivity to room light:	R / L / B	RIGHT	LEFT	
Excessive tearing:	R / L / B			
Droopy eyelid:	R / L / B			
Jerky eye movement:	R / L / B			
Keyhole pupil:	R / L / B			
Cloudy/milky appearance:	R / L / B			
Eyes different size/shape:	R / L / B			
Resists covering one eye more than other?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Corneal Reflection: Where is light reflected in both eyes? Draw a dot below where reflection is observed in each pupil.		
Family history of vision problems before age 5?	<input type="checkbox"/> Yes <input type="checkbox"/> No	RIGHT	LEFT	
Parent concerns about child's vision?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Describe:				

Hearing Summary		<input type="checkbox"/> PASS	<input type="checkbox"/> REFER	<input type="checkbox"/> REFER TO USDB-PIP	<input type="checkbox"/> INCONCLUSIVE
Report	Date	Eye Care Specialist (MD, OD, etc.)			
Ophthalmological report					
USDB vision report					
Other:					

OBSERVED EYE RESPONSES/VISUAL BEHAVIORS

Check each item observed, beginning at approximate developmental age.

Complete at least three consecutive sections, identifying both a baseline and ceiling.

BIRTH	
Responds to movement/light w/ blink reflex	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pupil responds to light on/off	<input type="checkbox"/> Yes <input type="checkbox"/> No
Makes momentary eye contact	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments	
1 MONTH	
Turns head and eyes to light source	<input type="checkbox"/> Yes <input type="checkbox"/> No
Regards face	<input type="checkbox"/> Yes <input type="checkbox"/> No
Follows movement horizontally, either side of midline	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments	
2 MONTHS	
Turns head to objects/lights on either side	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stares at objects or people	<input type="checkbox"/> Yes <input type="checkbox"/> No
Responds to another's smile w/ social smile	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments	
3 MONTHS	
Follows/tracks object 180°	<input type="checkbox"/> Yes <input type="checkbox"/> No
Regards own hands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Follows movement of people and objects	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments	
4 MONTHS	
Glances from one object to another	<input type="checkbox"/> Yes <input type="checkbox"/> No
Uses vision to reach 1-inch object at 12 feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Looks at 4-6 inch object at 3 feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments	
6 MONTHS	
Watches rolling tennis ball at 10 feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Uses vision to reach directly to object <input type="checkbox"/> Under reaches <input type="checkbox"/> Over reaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Uses eyes together	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments	

9 MONTHS	
Looks for fallen toy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eyes converge on moving toy within 4 in. of face	<input type="checkbox"/> Yes <input type="checkbox"/> No
Watches activity of adults 15-20 feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments	
12 MONTHS	
Recognizes familiar object (cup, toy) at 8-10 feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Looks at pictures in a book	<input type="checkbox"/> Yes <input type="checkbox"/> No
Looks at/picks up small object (raisin, cereal)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments	
18 MONTHS	
Uses vision to stack three 1-inch cubes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Looks at/points to pictures named	<input type="checkbox"/> Yes <input type="checkbox"/> No
Attends to 2-3 inch stationary object at 10 feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments	
24 MONTHS	
Imitates facial and hand movements	<input type="checkbox"/> Yes <input type="checkbox"/> No
Walks confidently on unfamiliar/varied surfaces	<input type="checkbox"/> Yes <input type="checkbox"/> No
Locates/matches identical objects visually	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments	
30-36 MONTHS	
Recognizes self in photo/mirror	<input type="checkbox"/> Yes <input type="checkbox"/> No
Imitates actions (finger plays, on, under, behind)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments	
NOTES & CONCERNS	