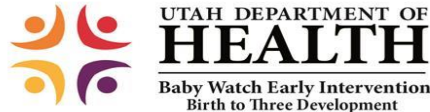


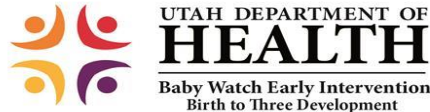
Health, Hearing & Vision Assessment

HEALTH ASSESSMENT	Date: By: RN Records Review Date: By: RN
Child's Name ☐ Male ☐ 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?	☐ Yes ☐ No	☐ Significant illnesses ☐ Hospitalizations ☐ Injuries ☐ Surgeries ☐ Seizures ☐ TBI **Describe:**	☐ Learning delays ☐ Developmental delays ☐ Mental health concerns **Describe:**
Prenatal exposure to alcohol, smoking, medications, or toxic substances?	☐ Yes ☐ No **List:**		
At birth, child health was:	☐ Stable ☐ Unstable **Describe:**		
If premature: ☐ IVH ☐ ECMO ☐ ROP	☐ Oxygen: # days __________ ☐ Ventilator: # days ________		

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

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



Health, Hearing & Vision Assessment

Growth		
Weight		PCTL
Lngth/Ht		PCTL
OFC		PCTL
Corrected PCTL?		☐ Yes ☐ No
Birth weight		PCTL
Birth length		PCTL

Medical Home

Regular well-child checks? ☐Yes ☐No

Date of most recent well-child check: ___________

Developmental screening? ☐Yes ☐No

Results:

Immunization Status

☐ Current for age (or corrected age)
☐ Not current; plans to get current
☐ Using modified schedule
☐ Does not immunize

Temperament

☐ Generally happy ☐ Irritable
☐ Calms easily ☐ Hard to calm
☐ Hyperactive ☐ Colicky

Interactive? ☐ Yes ☐ No

Sleep

☐ Sleeps thru night ☐ Reg sleep schedule
☐ Snores ☐ Mouth breather
☐ Naps/day _______ ☐ Awake/night _______
☐ Poor sleeper
Location: ☐ Crib ☐ Parents
Position: ☐ Back ☐ Stomach

Elimination

Stools/day ___________
☐ Liquid ☐ Loose ☐ Pasty
☐ Formed ☐ Hard
Wet diapers/day ___________
Normal M/F genitalia? ☐Yes ☐No

Respiratory

☐ On O2/NC ☐ Trach
☐ Respiration unlabored
☐ Breath sounds clear
☐ Cough ☐ Wheezing
☐ Rales ☐ Retractions

Cardiovascular

CCHD Screening ☐ Pass ☐ Fail
Apnea/Bradycardia ☐ Yes ☐ No
Normal heart sounds? ☐ Yes ☐ No
Describe:
Heart problems? ☐ Yes ☐ No
Type:

Musculoskeletal

☐ Normal gait
☐ Hypotonic ☐ Hypertonic
☐ Strength equal bilateral/upper/lower
☐ ROM
☐ Neck tightness
☐ Normal for age

Mouth

☐ Normal ☐ Teething ☐ Excessive drooling
☐ Mucous membranes pink/moist
If over 1 yr, has child seen dentist? ☐ Yes ☐ No
Dental caries? ☐ Yes ☐ No
Do you brush child's teeth? ☐ Yes ☐ No

Skin

☐ Normal ☐ Pale
☐ Intact, dry, good turgor ☐ Jaundice
☐ Rash ☐ Excoriation
☐ Edema ☐ Eczema
☐ Bruises ☐ Birth marks
Describe:

Allergies

☐ No known allergies
☐ Allergies
List:

☐ Food allergies
List:

Health Summary

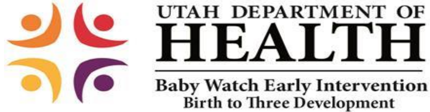
☐ Child appears to be in good general health.

☐ Child has some health concerns.

☐ Health concerns are being addressed with medical professionals.

☐ There are some concerns NOT currently being addressed.

NOTES:



Health, Hearing & Vision Assessment

HEARING ASSESSMENT

Date: By:

Newborn hearing screening ☐ Pass ☐ Fail
If Fail, follow up? ☐ Yes ☐ No Describe:
CMV test results? ☐ Pos ☐ Neg ☐ Not completed
History of ear infections? ☐ Yes ☐ No How many?
History of ear tubes? ☐ Yes ☐ No Dates:
Fam history of childhood HL? ☐ Yes ☐ No Describe:
Concerns about child's hearing? ☐ Yes ☐ No Describe:

Facial Features:
☐ Ear tags/pits
☐ Low, lopsided atypical ears
☐ Cleft lip and/or palate
☐ Irregularly spaced eyes/ears

Hearing Summary ☐ **PASS** ☐ **REFER** ☐ **REFER TO USDB-PIP** ☐ **INCONCLUSIVE**

Assessment	Date	Right Ear	Left Ear
Audiological exam		☐ Pass ☐ Fail	☐ Pass ☐ Fail
OAE		☐ Pass ☐ Fail	☐ Pass ☐ Fail
Tympanogram		☐ Pass ☐ Fail	☐ Pass ☐ Fail

VISION ASSESSMENT

Date: By: RN

Eye Appearance (indicate R, L, or B for all that apply)

Tracking: R / L / B
Fixates: R / L / B
No pupil response to light: R / L / B
Excessive sensitivity to room light: R / L / B
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? ☐ Yes ☐ No

Family history of vision problems before age 5? ☐ Yes ☐ No
Parent concerns about child's vision? ☐ Yes ☐ No
Describe:

Misalignment (do not test under 3 months adjusted age)
Misalignment Observed? ☐ Yes ☐ No
☐ With glasses ☐ Without glasses
If misalignment noticeable, draw where eyes usually rest.
RIGHT **LEFT**

Corneal Reflection: Where is light reflected in both eyes?
Draw a dot below where reflection is observed in each pupil.
RIGHT **LEFT**

Vision Summary ☐ **PASS** ☐ **REFER** ☐ **REFER TO USDB-PIP** ☐ **INCONCLUSIVE**

Report	Date	Eye Care Specialist (MD, OD, etc.)
Ophthalmological report		
USDB vision report		
Other:		

Health, Hearing & Vision Assessment

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	□ Yes □ No
Pupil responds to light on/off	□ Yes □ No
Makes momentary eye contact	□ Yes □ No
Comments	

1 MONTH	
Turns head and eyes to light source	□ Yes □ No
Regards face	□ Yes □ No
Follows movement horizontally, either side of midline	□ Yes □ No
Comments	

2 MONTHS	
Turns head to objects/lights on either side	□ Yes □ No
Stares at objects or people	□ Yes □ No
Responds to another's smile w/ social smile	□ Yes □ No
Comments	

3 MONTHS	
Follows/tracks object 180°	□ Yes □ No
Regards own hands	□ Yes □ No
Follows movement of people and objects	□ Yes □ No
Comments	

4 MONTHS	
Glances from one object to another	□ Yes □ No
Uses vision to reach 1-inch object at 12 feet	□ Yes □ No
Looks at 4-6 inch object at 3 feet	□ Yes □ No
Comments	

6 MONTHS	
Watches rolling tennis ball at 10 feet	□ Yes □ No
Uses vision to reach directly to object □ Under reaches □ Over reaches	□ Yes □ No
Uses eyes together	□ Yes □ No
Comments	

9 MONTHS	
Looks for fallen toy	□ Yes □ No
Eyes converge on moving toy within 4 in. of face	□ Yes □ No
Watches activity of adults 15-20 feet	□ Yes □ No
Comments	

12 MONTHS	
Recognizes familiar object (cup, toy) at 8-10 feet	□ Yes □ No
Looks at pictures in a book	□ Yes □ No
Looks at/picks up small object (raisin, cereal)	□ Yes □ No
Comments	

18 MONTHS	
Uses vision to stack three 1-inch cubes	□ Yes □ No
Looks at/points to pictures named	□ Yes □ No
Attends to 2–3 inch stationary object at 10 feet	□ Yes □ No
Comments	

24 MONTHS	
Imitates facial and hand movements	□ Yes □ No
Walks confidently on unfamiliar/varied surfaces	□ Yes □ No
Locates/matches identical objects visually	□ Yes □ No
Comments	

30-36 MONTHS	
Recognizes self in photo/mirror	□ Yes □ No
Imitates actions (finger plays, on, under, behind)	□ Yes □ No
Comments	

NOTES & CONCERNS