Figure 4.2

Sample Family Questionnaire

Family Questionnaire

General Information

Date: _____

Child's name: _____ Date of birth: _____

Visual diagnosis: _____

Parents' names: _____

Siblings in the home (names and ages): _____

Adults in the home (names and ages): _____

Language(s) used in the home: _____

Pediatric ophthalmologist: _____

Phone: _____ Email: _____

Date of last appointment: _____

Pediatrician: _____

Phone: _____ Email: _____

Date of last appointment: _____

Other medical professional(s): _____

Phone: _____ Email: _____

Date(s) of last appointment: _____

Medications: (name and frequency of dosages):

_____

Other difficulties:_____

Surgeries (past type and date): _____

Surgeries (upcoming): _____

Do you have any questions about the information provided by any of the doctors?

_____

Questions about Your Baby

1. What makes you happy about your baby? _____
2. What about your baby worries you? _____
3. Do you have a nickname(s) for your baby? _____
4. What are your baby's strongest abilities? _____
5. What are your baby's most difficult problems? _____
6. Does your baby use special equipment for support (e.g., wheelchair, foot brace, cane)?

   _____

7. Does your baby have difficulty sleeping or distinguishing day from night?

   _____

8. Does your baby cry? ◯ A lot ◯ Not very often ◯ Only when uncomfortable
9. How would you describe your baby's personality (e.g., easygoing, fussy, nervous, calm, cuddly, stand-offish)? _____
10. What do you think your baby sees? _____
11. What do you want to learn?

    _____

12. How does your baby react to the following?

	Likes	Does Not Like	Neutral
Objects	○	○	○
Sounds	○	○	○
Touch	○	○	○
Foods	○	○	○
People	○	○	○
Environment	○	○	○
Songs	○	○	○
Other	○	○	○

Additional information about your baby:

_____