PATIENT NAME_____**DATE OF BIRTH**_____

VISION RISK ASSESSMENT BIRTH TO 3 YEARS

1. Does your infant or child wear eye glasses? Y N
2. If so, when was their last eye exam? _____
3. Does your child seem to see well? Y N
4. Does your child hold objects close to their face when trying to focus? Y N
5. Do your child's eyes appear unusual or seem to cross, drift or be lazy? Y N
6. Do your child's eyelids droop or does one eyelid tend to close? Y N
7. Have your child's eyes ever been injured? Y N

(PHYSICIAN USE ONLY)

COMMENTS: NO SCREENING NEEDED

REFER TO OPTHAMOLOGY

Eye Consultants of Atlanta
Scottish Rite 404-255-2419
Marietta 770-424-5669

Cartersville Pediatric Associates
958A Joe Frank Harris Pkwy
Cartersville, GA 30120

Provider Signature:_____