



**InfantSEE® Clinical Reporting Form**  
<http://exam.infantsee.org>

Date of Exam \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender:  M  F      Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_      Age (in Months): \_\_\_\_\_

Patient City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth History: Born Premature?  Yes  No    If yes: born at how many weeks premature \_\_\_\_\_

Delivery Complications: \_\_\_\_\_

Ethnic Origin:     Hispanic     Caucasian     African American     Native American     Asian     Other

Insurance:  Yes  No    If yes:  Private     CHIP     Medicaid     Other, specify \_\_\_\_\_

**How did you find out about InfantSEE®?**

- |                                          |                                                  |                                               |
|------------------------------------------|--------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Current Patient | <input type="checkbox"/> Radio                   | <input type="checkbox"/> Parenting Classes    |
| <input type="checkbox"/> Friend/Family   | <input type="checkbox"/> Internet                | <input type="checkbox"/> Other, specify _____ |
| <input type="checkbox"/> Mail            | <input type="checkbox"/> Newspaper               |                                               |
| <input type="checkbox"/> TV              | <input type="checkbox"/> Primary Health Provider |                                               |

**Yearly Household Income: (Required for HRSA Grant States Only)**

- |                                             |                                            |                                              |
|---------------------------------------------|--------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Less than \$20,000 | <input type="checkbox"/> \$40,000-\$59,999 | <input type="checkbox"/> \$80,000-\$99,999   |
| <input type="checkbox"/> \$20,000-\$39,999  | <input type="checkbox"/> \$60,000-\$79,999 | <input type="checkbox"/> More than \$100,000 |

**Medical History** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ASSESSMENT (Use InfantSEE® Clinical Assessment Criteria)**

- Ocular Motility**     No Concern     Concern     Problem \_\_\_\_\_
- Binocularity**     No Concern     Concern     Problem \_\_\_\_\_
- Refractive Status**     No Concern     Concern     Problem \_\_\_\_\_
- Visual Acuity**     No Concern     Concern     Problem \_\_\_\_\_
- Ocular Health**     No Concern     Problem \_\_\_\_\_
- Dilation**     Yes     No
- Plan**     No Concerns  
 Concerns and in need of follow up care in \_\_\_\_\_ months or \_\_\_\_\_ weeks

Referral to: \_\_\_\_\_

Recommended follow-up: \_\_\_\_\_ years of age

OD Name/AOA Number	State	Zip Code	Date