INSIGHT
FAMILY EYE CARE

Insight Family Eye Care
Questionnaire For Ages 1-5

Patient Name: _____Age: _____
Name of Daycare/Pre-School (if applicable)_____
Date: _____

Please identify how often your child experiences the behaviors on this list. Place a score of 1 if you have never seen this behavior. Place a score of 5 if you see this behavior all the time.

Behavior:	Place Number:				
	1. (Never)	2. (Seldom)	3. (Occasionally)	4. (Frequently)	5. (All the time)
1. Does your child sit close to the television when watching a program?					
2. Do your child's eyes seem to be easily irritated?					
3. Does your child rub their eyes often?					
4. Does your child squint or blink often?					
5. Do either of your child's eyes cross? Both?					
6. Does your child run into things/knocks things over? Do they seem to be clumsy?					

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