SMALL CHILDREN'S VISION CHECKLIST (AGES 1-5)

Patient's name _____Age _____Date _____

Please estimate how often your child exhibits the behaviors on this list. Give a score of 1 if you never observe the behavior. Give a score of 6 if the behavior happens all the time.

	Symptom	Please Circle Never ----------Always					
1.	Blinks or squints to see.	1	2	3	4	5	6
2.	Sits close to TV.	1	2	3	4	5	6
3.	Holds books close.	1	2	3	4	5	6
4.	Runs into things.	1	2	3	4	5	6
5.	Rubs eyes.	1	2	3	4	5	6
6.	One or both eyes cross.	1	2	3	4	5	6

What concerns you most about your child's vision?

Why?

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