CONFIDENTIAL

KEITH MURPHY

OPTICIANS

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Introduction

Please answer as much of this questionnaire as possible. Don't worry if you cannot answer all the questions. If you are not sure, just leave them blank, and we will discuss any uncertainties with you at the assessment. If you are filling this in for your child **please complete the visual symptoms and headache sections by asking your child.**

Patients Name………………………………………………………………………..

Address………
……
…………………………..Post Code………………………….

Telephone Number …………………………………………… Date of Birth ……………………………

Date of appointment ………………………………………………………………………………………

Who referred you to us?…………………………………………………..………………………………

Please give their address……………………………………………………………………………….

Please give you GP's name and address ……………………………….……..…………………………

What school or College do you attend? ……………………………………………………………………….

Please state the address………………………………………………………………………………...

Class/Course ……………………………………………….

Teacher's/Form Tutors Name ……………………………….

Name of School's Special Educational Needs Coordinator

………………………………………………………………………..

Please state briefly the reason for this assessment ……………………………………………………………

………..

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Has your child been assessed by an educational psychologist, occupational therapist or specialist teacher?

Yes ڤ No ڤ

If yes please give their details and what their conclusions were?

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Could you please let us have a copy(s) of any reports prior to attending for the visual assessment.

Has your child undergone any treatment/therapy programme for their learning problems? Yes ڤ No ڤ

If yes please give details of the program and when or if they completed it?
…………………………………………………………..

Are they receiving extra help at school? Yes ڤ No ڤ

What form does this take? ……………………………………………………..

Visual History

Date of last visit to optometrist/optician: ……………………………………………………………………

Name and address of optometrist (if known) ………………………………………………………………

Were you given glasses? Yes ڤ No ڤ

If yes, when are they worn? ……………………………………………………………………………..

Has anyone noticed the eyes turning in or out? Yes ڤ No ڤ

If yes, at what age was this first noticed, and how long did it last?
…………………………………………………

Has your child ever had an eye operation? Yes ڤ No ڤ

If yes please give details, if you can, of what the operation was for and when it was performed.
………

Has your child ever been given eye exercises or patching? Yes ڤ No ڤ

If yes, please give details of the treatment and at what age it was started.
………………………………………………………………………………………..

Visual Symptoms

When you look at the board at school, is it usually quite clear? Yes ڤ No ڤ

When you are reading or writing do the words ever:-

Go blurred Yes ڤ No ڤ

Words seem to run together Yes ڤ No ڤ

Jump around Yes ڤ No ڤ

Go smaller or bigger Yes ڤ No ڤ

Fade or disappear Yes ڤ No ڤ

Get faint colours around them Yes ڤ No ڤ

Appear to fall off the page Yes ڤ No ڤ

Seem hidden by the white on the page Yes ڤ No ڤ

Do you ever see 2 numbers or words on the paper when you know there is only one Yes ڤ No ڤ

Does reading or writing ever make you cry Yes ڤ No ڤ

Do your eyes sting or burn after reading for a while Yes ڤ No ڤ

Do you ever feel you have to cover one eye to help get reading or desk work done	Yes ق No ق
Do you have to wait to get your eyes clear when you look up from reading or desk work	Yes ق No ق
Do you get sore eyes when reading	Yes ق No ق

Visual Behaviour

Holding books at arms length	Yes ق No ق
Changing the distance of printed material	Yes ق No ق
Rubbing eyes whilst reading	Yes ق No ق
Screwing the eyes up whilst reading	Yes ق No ق
Frequent excessive blinking	Yes ق No ق
Moving the head whilst reading	Yes ق No ق
Following text by using a finger or guide to keep place	Yes ق No ق
Reverses letters	Yes ق No ق
Skipping letters	Yes ق No ق
Skipping words	Yes ق No ق
Skipping lines	Yes ق No ق
Slow at reading	Yes ق No ق
Tires easily	Yes ق No ق
Poor attention span	Yes ق No ق
Disruptive behaviour in class	Yes ق No ق
Poor general co-ordination	Yes ق No ق
Poor handwriting	Yes ق No ق
Sensitive to light	Yes ق No ق
Poor memory of text read	Yes ق No ق
Vocalises when reading silently	Yes ق No ق

Visual habits

Avoids reading where possible	Yes ق No ق
Only reads comics or books with lots of pictures	Yes ق No ق
Moves books around when reading	Yes ق No ق
Fidgets a lot	Yes ق No ق

Developmental history

Was this child born prematurely? No ڤ Yes ڤ
If yes, how many weeks? _____________

Did this child have any difficulties in the following areas? Sitting No ڤ Yes ڤ

Crawling No ڤ Yes ڤ Walking No ڤ Yes ڤ Speech No ڤ Yes ڤ Emotional No ڤ Yes ڤ

Medication and general health

Has your child been on any regular medication? No ڤ Yes ڤ

If yes please give details. ………………………………………………………………………………………..
……

Please list any operations or severe illness that your child had in the first year of life……………………….
……

Has you child had any hearing problems?...

Has your child had grommets fitted or had recurring ear infections in the first 2years of life?
....

Has your child ever suffered from epilepsy, fits or convulsions? No ڤ Yes ڤ

Does your child have any allergies? No ڤ Yes ڤ

If yes please list. ____

Is your child generally fit and healthy? No ڤ Yes ڤ

Family Visual History (please tick the appropriate boxes)

	Long sighted	Short Sight	Astigmatism	Amblyopia (lazy eye)	Strabismus (eye turns)	Colour defect	Other Please Specify
Parents							
Siblings							
Uncle/aunt							
Grandparent							

General family history

Has anyone in the family experienced difficulties in reading or been diagnosed with a learning difficulty or autism? No ڤ Yes ڤ

If yes, who? ……………………………………………………………………………………………………….

Headaches

Does your child suffer from regular headaches? No ڤ Yes ڤ

If yes how often have they occurred in the last 2 months? (e.g. daily, 3x weekly etc.)

What is the child doing when the headaches occur? (e.g. reading, at school, TV, playing etc.) …………..

……

How bad are the headaches usually?

Slight No ڤ Yes ڤ Mildly disturbing No ڤ Yes ڤ Needs pain killers No ڤ Yes ڤ

Needs to go to bed No ڤ Yes ڤ Has to take time off school No ڤ Yes ڤ

Where on the head so they usually occur?

Top No ڤ Yes ڤ Temple No ڤ Yes ڤ Forehead No ڤ Yes ڤ

Back No ڤ Yes ڤ In, around or behind the eye No ڤ Yes ڤ

Is the pain:-

Sharp? No ڤ Yes ڤ Dull ache? No ڤ Yes ڤ Sharp stabbing? No ڤ Yes ڤ

Throbbing? No ڤ Yes ڤ Other? (please specify)………………………………………………….

How long does the pain usually last? ………………………………………….

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<u>Please sign the attached consent form and return the completed questionnaire and any copies of reports in advance of the visual assessment.</u>

Please feel free to ask the Optometrist any questions you may have

Thank you for your help in carefully completing this questionnaire. It will help us to choose the most appropriate tests and examinations for your child when we see him or her, and enable us to spend more time with your child.

CONSENT

It is often beneficial for us to discuss our examination results with your child's school and/or other healthcare professionals involved in his or her care. Please sign below to indicate that you authorise this exchange of information and to indicate you have read and understood the conditions attached to vision therapy appointments.

From time to time, we also like to review our procedures and audit our patient records. On occasions, we may use the results for research. When this is done, we NEVER reveal the name or addresses of our patients to any third party. We would be grateful for your consent to use the data from examinations and therapy (if any) to help us, but we need your authority to do so.

I consent to sharing information with schools professional carers and to use the data for research and audit purposes.

Signature …………………………………………….. Date …………………………….
Print name and initials ………………………………………….. If you are filling this in on behalf of a child please state your relationship to the child………………………