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Parents Vision & Learning Questionnaire

This questionnaire will provide important information to me about your child. I strive to understand the total child, especially but not only, his or her vision. Thank you for taking the time to complete this form.

Wendy S. Yeh, OD

Child's Name: _____

Your Name: _____

Your relation to child: _____

1. In your own words, please state your main concern about your child:

2. What has occurred that has led your to schedule comprehensive vision testing for your child?

3. Was there anything unusual about your child's birth or development? Yes No
If yes, please describe:

4. Are there any behavior problems at school or home? Yes No
If yes, please describe:



Vision & Learning Questionnaire - Parents

5. Does your child report or have you noticed any of the following?

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Blurry Eyesight during reading or writing. |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches associated with visual tasks. |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyestrain or tired eyes associated with visual tasks. |
| <input type="checkbox"/> | <input type="checkbox"/> | Print moves, doubles, or runs together while reading. |
| <input type="checkbox"/> | <input type="checkbox"/> | Blinks or rubs eyes excessively. |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes become red or water too much with desk work. |
| <input type="checkbox"/> | <input type="checkbox"/> | Gets too close to book or desk work. |
| <input type="checkbox"/> | <input type="checkbox"/> | Closes or covers one eye during visual tasks. |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequently loses place while reading or copying. |
| <input type="checkbox"/> | <input type="checkbox"/> | Often skips over words or lines of text while reading. |
| <input type="checkbox"/> | <input type="checkbox"/> | Often re-reads words or lines unintentionally. |
| <input type="checkbox"/> | <input type="checkbox"/> | Over-reliance on finger or marker to keep place while reading. |
| <input type="checkbox"/> | <input type="checkbox"/> | Moves/turns head excessively during reading or other desk work. |
| <input type="checkbox"/> | <input type="checkbox"/> | Unusual fatigue or declining attention with desk work. |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor general coordination and balance. |
| <input type="checkbox"/> | <input type="checkbox"/> | Reverses letters or numbers. (ex: b for d, p for q) |
| <input type="checkbox"/> | <input type="checkbox"/> | Letter sequence or number sequence errors. (ex: was - saw, on-no) |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent word recognition errors for common grade level words. |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent written spelling errors for common grade level words. |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor penmanship. |
| <input type="checkbox"/> | <input type="checkbox"/> | Copying from book to paper is slow or difficult. |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty completing written assignments. |
| <input type="checkbox"/> | <input type="checkbox"/> | Avoids reading or other near vision tasks. |

6. Do you think your child's achievement and performance in school are up to her/his potential? Yes No If no, do you have or have you been given a reason for the discrepancy?



Vision & Learning Questionnaire - Parents

7. Has a grade been repeated? Yes No If yes, which one? _____

8. Has your child had tutoring, remedial assistance/intervention, or special education?
Yes No If yes, by whom and when:

9. Please rate your child's academic performance:

	Above Average	Average	Below Average
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Are there other family members with learning problems? Yes No
If yes, who and to what extent?

11. Please give a brief description of the nutritional philosophy and habits in the child's home:

12. Please give a brief description of your child's personality:

It is often beneficial for us to discuss examination results and send reports to your child's school and other professionals involved in her/his care. Please sign below to authorize this exchange of information.

Parent or Guardian Signature: _____ Date: _____