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Vision & Learning Questionnaire

This questionnaire will provide important information to the doctor about your vision. We strive to understand your habits and how they affect your vision. Thank you for taking the time to complete this form.

☐ **Wendy S. Yeh, O.D.**
☐ **Judy Cao, O.D.**

Patient Name: ____

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

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

3. Was there anything unusual about your vision development? Yes ☐ No ☐
   If yes, please describe:
   ____
   ____
   ____

4. Are there any vision problems in your work place? Yes ☐ No ☐
   If yes, please describe:
   ____
   ____

Vision & Learning Questionnaire

5. Do you report or have you noticed any of the following?

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

6. Do you think your work performance as far as vision is concerned is up to your potential?

☐ Yes ☐ No

If no, do you have or have you been given a reason for the discrepancy?

____

____

____

Vision & Learning Questionnaire

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

8. Please give a brief description of the nutritional philosophy and habits in your home:
   ____
   ____
   ____

It is often beneficial for us to discuss examination results and send reports to you or your physician of choice. Please sign below to authorize this exchange of information.

Patient Signature:________________________________ Date:___________