KEYES eyecare
EXPERTS IN VISION

QUESTIONNAIRE FOR COMPLETION PRIOR TO THE EYE EXAMINATION

Introduction

Please complete as much of this questionnaire as possible and *bring it with you to the eye examination.* This questionnaire is designed for children and adults. We apologise to adults for the child-like ways that some of the questions are phrased.

Parents will need to ask their child about some of the questions (e.g., visual symptoms), although parents may be able to answer others by themselves (e.g., details of your child's birth). If you are not sure about anything, please just leave a gap: we will discuss any uncertainties at your appointment.

Full name of person to be examined:..

Address:..

....

Date of birth:.......................... Date of appointment:..........................

Who referred you to us:..

Please give their address:..

....

Developmental History

Please state whether the pregnancy was full term, or how many months/weeks early or late you were born:..

Please state whether the birth was normal, or give details of any complications (for example, was it a forceps delivery?):..

....

Please list any severe illnesses/operations that you had in your first year, with approximate age at the time:..

....

Learning Difficulties

Please tick if you have had any specific difficulties at school with the following:

reading spelling writing maths other ....

....

Has a psychologist ever assessed you for specific learning difficulties? yes no

If yes, please stated when and what her/his diagnosis was:..

....

(please bring any report you may have of a psychologist's assessment to the eye examination)

Visual History

Date of last visit to an optician/optometrist:..

Optometrist's or optician's name and address(if known):..

....

Reason for last examination:..

Were you given glasses? yes no

If so, when are they worn (e.g. just for reading)?..

If you have been prescribed glasses in the past, please state your approximate age(s) when you were given these:..

Has anyone ever noticed your eye(s) turning inwards or outwards? yes no

If yes, at what age, how often , and how long did it normally last?..................................

....

Have you ever had an eye operation? yes no Please give any details you can of what the operation was for and how old you were at the time...

....

....

Have you ever received eye exercises or patching? yes no Please give details of the type of treatment and your age at the time..

....

Have you ever used a coloured filter? yes no Please give details of the type of filter (plastic sheet or lenses), when you started using it, and for how long..

....

Visual Symptoms

When you look at writing on the board at school (or, for adults, road signs in the distance), is it normally clear? yes no

Does writing on the board ever go blurred? yes no

When you are reading or writing in a book, is it normally clear? yes no

Do words in a book ever :-

- go blurred? yes no
- jump around? yes no
- go smaller/bigger? yes no
- fade or disappear? yes no
- get faint colours round them? yes no

Do you ever experience difficulty changing focus from things in the distance (e.g., on the board) to at near (e.g., in a book)?

yes no

Do you ever experience double vision (see two things when there is only one)?

yes no

Do you see coloured patterns or shapes (perhaps like coloured ribbons) when your eyes are closed that you can't see when your eyes are open?

yes no

Do you find you want to close your eyes to rest them?

yes no

If you do want to rest your eyes, please underline which of the following describes when.

Generally through the day	Soon after starting close work	After reading or looking in the distance for a while

other..

Do you ever experience sore or tired eyes?

yes no

If you do suffer from sore or tired eyes, please underline which of the following describes what makes your eyes feel sore or tired:

reading for a long time	reading for a short time	looking in the distance for a long time	looking in the distance for a short time

other..

General Health

Have you ever suffered from epilepsy, or any fits or convulsions? yes no

Are you in good physical condition and healthy? yes no

If no, please give details:..

....

Please list any pills or medicines that you are currently using:..............................

....

Headaches

Please think of the headaches you (or your child) have had over the last month, and whether they have been getting more frequent or less frequent. Use this information to arrive at your best guess as to how many headaches have occurred in the last **12 months**, and write the number here.................

Think of the worst headache in the last 12 months.

- How bad was it?

mildly distracting? yes no
disturbing? yes no
so bad you had to take time off school/work? yes no
so bad you had to go to bed? yes no

If the headaches are mild or infrequent, you may find it difficult to answer some of the following questions concerning headaches. If so, just leave a blank and please turn to page 6 and continue with the questionnaire there.

Approximately, how old were you when you first started experiencing headaches like those that you experience nowadays?..

What is the pain usually like? ....

Is the pain pulsating (throbbing)? yes no

Is the pain made worse by routine physical exercise (e.g., climbing stairs): yes no

In general, where is the pain usually located?

top of head? yes no
back of head? yes no
forehead both sides? yes no
forehead one side? yes no
right head/temple? yes no
left head/temple? yes no
in or around the eye(s)? yes no

elsewhere (please specify)..

Please tick the box that most accurately describes whether the pain is on one or both sides of your head:

always on one side	usually on one side	equally often one side or both sides	usually on both sides	always on both sides

How long does the pain usually last? (specify with/without medication)..................................
....

Please name any medications that have been prescribed by a doctor for headaches

....

Do you feel ill in any other way during headaches? For example, do you suffer from:

loss of appetite?	yes no	difficulty with speech?	yes no
nausea?	yes no	dizziness?	yes no
vomiting?	yes no	sensitivity to light?	yes no
numbness?	yes no	sensitivity to noise?	yes no
tingling?	yes no	visual disturbances?	yes no
feeling of weakness?	yes no		

other (please specify)..

Do any of the above occur as a warning before the headache starts? yes no

If "yes", please state which..

Do the headaches tend to start at any particular time of day?

always often sometimes never

If "yes", please state when..

Please select any activities that you know can bring a headache on:

in car	television	reading	computers	cinema
schoolwork	weekends	exercise	chocolate	sweets

Other (please specify):..

Visual Behaviour

Have you or anyone else ever noticed that you do any of the following?

Hold reading unusually close/far:	**Yes No**	Confuse letters or words:	**Yes No**
Close or cover one eye:	**Yes No**	Reverse letters or words:	**Yes No**
Frequently rub the eye(s):	**Yes No**	Skip or omit words or lines:	**Yes No**
Blink excessively:	**Yes No**	Read slowly:	**Yes No**
Tilt head when reading or writing:	**Yes No**	Tire easily/Short attention span:	**Yes No**
Move head when reading:	**Yes No**	Poor general coordination:	**Yes No**
Use finger as a marker:	**Yes No**	Light sensitive:	**Yes No**

Family History

Did parents or any brothers or sisters have learning problems?

yes no: If yes, state who (e.g. father)..

Did parents or any brothers or sisters ever have a turning eye, patching, or eye exercises?

yes no: If yes, state who ....

Did parents or any brothers or sisters ever have any eye diseases (e.g., glaucoma, “lazy eyes”, etc.)?

yes no: If yes, state who and what disease ....

Did parents or any brothers or sisters ever have migraine headaches?

yes no: If yes, state who ....

Did parents or any brothers or sisters have a colour vision defect (colour blindness)?

yes no: If yes, state who ....

Did any relatives ever have epilepsy? yes no: If yes, state who..

Please add any other comments below and bring this questionnaire with you to the eye examination.

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Thank you for your help