Name :
Address:

Date of birth:
Date of completion:

How did you hear about us: :

Developmental History
Was the pregnancy full term yes no

If not how many months/weeks early or late were you born:

Was the birth normal yes no

If no, please give details of any complications (for example, was it a forceps delivery).

Please list any significant illnesses/operations that you had in your first year.

Learning Difficulties
Please circle if you have had any specific difficulties with:

reading spelling writing maths other (please state)

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

If yes, please state when and the conclusion:

(please bring any report you may have to your appointment)

Visual History
Approx. date of last visit to an optician:
Optician visited:
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

Please give any details (eg age, which eye, how often).

Have you ever had an eye operation? yes no

Please give details (eg age and what the operation was).

Have you ever received eye exercises or patching? yes no

Please give details (eg age andwhat you were asked to do).

Have you ever used coloured lenses or overlay? yes no

Please give details (eg when, for how long, did it help and colour).

Visual Symptoms

When you look at writing in the distance eg on the board at school or road signs,is it **normally** clear? yes no

Does writing in the distance **ever** go blurred? 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 to things close up? 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 circle 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

Do you feel that you can recall the colour of objects:

much better than other people	better than other people	about the same as other people	worse than other people	much worse than other people

Do you think you can discriminate the colour of objects:

much better than other people	better than other people	about the same as other people	worse than other people	much worse than other people

General Health

Are you in good health? yes no

If no, please give details:

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

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

Headaches

Please think of the headaches you have had over the last month, and whether they have been getting more frequent or less frequent.

How many headaches have occurred in the last **12 months** (approx.)?

Think of the **worst** headache you have had in the last 12 months. Was it:

Bad enough that you had to take time off school/work yes no
So bad you had to go to bed yes no

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

In general, where is the pain usually located?

In terms of which side of your head is affected, please circle which best describes where your headaches occur:

Always on one side Usually on one side Equally often on 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
nausea? yes no
vomiting? yes no
numbness? yes no
tingling? yes no
feeling of weakness? yes no

difficulty with speech? yes no
dizziness? yes no
sensitivity to light? yes no
sensitivity to noise? yes no
visual disturbances? 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? yes no
If "yes", 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 anyone in your family have:

1. learning problems? yes no If yes, who and what?

2. A turning eye, patching, or eye exercises? yes no If yes, who?

3. Any eye diseases (e.g., glaucoma, "lazy eyes", etc.)? yes no If yes, who and what?

4. Migraine headaches? yes no If yes, who?

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

Is there anything else you would like us to know?