

Keith Holland & Associates

optometrists

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PLEASE ENSURE THIS QUESTIONNAIRE IS RETURNED AHEAD OF THE APPOINTMENT SO THAT WE CAN PREPARE FULLY FOR THE ASSESSMENT

Pre-Assessment Questionnaire

This questionnaire will allow us tailor the appointment towards the patient by providing valuable background information. Therefore, please fill in as fully as you are able.

SECTION 1 - PATIENT DETAILS

Patient's Full Name

Home Address

Postcode

Home Telephone Number Parent's Daytime Number

Email address Fax

Date of Birth School

Who referred you to our practice?

Name and address of G.P.

DETAILS OF ASSESSMENT: a.m / p.m on:

Q1. Please try to explain your chief concerns that have led you to seeking our help:

SECTION 2 – PREVIOUS VISUAL HISTORY

Has there been any previous visual care? (please circle) YES / NO

Please describe in detail including information on any eye tests tests, glasses, any orthopedic exercises, surgery, patching etc that may have been used. If you have a copy of the current spectacle prescription, please bring it with you to the assessment.

SECTION 3 - VISUAL SIGNS

Does your child report any of the following? (Please tick as appropriate, if very common use two ticks)

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Skip over or omit words when reading |
| <input type="checkbox"/> | <input type="checkbox"/> | Use finger or bookmark to help keep place |
| <input type="checkbox"/> | <input type="checkbox"/> | Complain of blurred vision whilst reading |
| <input type="checkbox"/> | <input type="checkbox"/> | Complain of print doubling, "running together" or "wobbling about" |
| <input type="checkbox"/> | <input type="checkbox"/> | Complaints of headaches with visual tasks |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive tiredness after close work |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain or discomfort around the eyes with close work |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive eye rubbing or blinking |
| <input type="checkbox"/> | <input type="checkbox"/> | Frowning, scowling or squinting with visual tasks |
| <input type="checkbox"/> | <input type="checkbox"/> | Closing or covering one eye, either when working or viewing at distance |
| <input type="checkbox"/> | <input type="checkbox"/> | Reddened eyes or lids |
| <input type="checkbox"/> | <input type="checkbox"/> | One eye turning in, out, up or down at any time |
| <input type="checkbox"/> | <input type="checkbox"/> | Moving in and out when working (constantly varying working distance) |
| <input type="checkbox"/> | <input type="checkbox"/> | Moving very close to work or holding books very close |
| <input type="checkbox"/> | <input type="checkbox"/> | Avoids close work |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in copying from blackboards / whiteboards |
| <input type="checkbox"/> | <input type="checkbox"/> | Reversal of letters or numbers when reading |

SECTION 4 – GENERAL SIGNS

- | YES | NO | |
|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty with co-ordination |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems with balance |
| <input type="checkbox"/> | <input type="checkbox"/> | Prone to travel sickness |
| <input type="checkbox"/> | <input type="checkbox"/> | Untidy handwriting |
| <input type="checkbox"/> | <input type="checkbox"/> | Discomfort in hand when writing |
| <input type="checkbox"/> | <input type="checkbox"/> | Letter formed backwards in writing |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulties with spelling |
| <input type="checkbox"/> | <input type="checkbox"/> | Spelling errors generally phonetic |
| <input type="checkbox"/> | <input type="checkbox"/> | Can learn spellings well for tests |

Please give further information if you feel it would be of help:

SECTION 5 – DEVELOPMENTAL HISTORY

Were there any complications during pregnancy or at birth? (Please give details)

Was birth premature? **YES / NO** Was birth weight low? **YES / NO**

Did child thrive? **YES / NO** Jaundice? **YES / NO**

Did birth involve: (please tick) Caesarian Section Forceps

At what age did your child: Crawl? Was crawling normal? **YES / NO**

Walk? Talk? Was speech therapy needed? **YES / NO**

Is speech now clear? **YES / NO**

SECTION 4 – HEARING

Have there been any hearing problems? **YES / NO** **If answer is NO please skip to Section 5**

If so, please detail including which ear was involved (if known)

Have grommets been used? **YES / NO**

Is hearing now reported to be normal? **YES / NO**

Does child respond well to verbal instructions? **YES / NO**

SECTION 5 – HEALTH

Does your child have any health problems? **YES / NO** *If yes, please give details*

Does your child suffer from allergies? **YES / NO** *If yes, please give details*

Does your child have any nutritional or eating problems? **YES / NO** *If yes please give details*

SECTION 6 – FAMILY HISTORY

Is there any family history of visual problems? **YES / NO** *If yes please give details*

Is there any family history of dyslexia or learning difficulty? **YES / NO** *If yes please give details*

Is there any family history of hyperactivity, attention difficulties or speech problems? **YES / NO**

If yes please give details:

SECTION 7 – LATERALITY

Is your child: (please tick) Left Handed Right Handed Ambidextrous

Hand dominance in family: (please indicate **L** – for left handed, **R** – for right handed or **A** – for ambidextrous)

Father **Mother** **Siblings: 1:** **2:** **3:** **4:**

Does child confuse directions and lefts and rights? **YES / NO**

Is there similar confusion in the family? (**Y or N**) Maternal side Paternal side

SECTION 8 – SCHOOL

Have your child’s school expressed any concerns about academic progress? **YES / NO**

Is your child receiving extra support either in or out of school? **YES / NO**

Does your child experience difficulties in other subjects apart from English? **YES / NO**

If yes please give details:

Have there been any behavioural problems? **YES / NO** *If yes please give details:*

Have any other tests been carried out? (e.g. educational psychologist evaluation) **YES / NO**
IF YES PLEASE COULD YOU LET US SEE A COPY OF ANY REPORTS THAT HAVE BEEN PREPARED

In your opinion what are your child’s best subjects?

Your child’s worst subjects?

What are your child’s special interests and hobbies?

Please tick the following as appropriate:

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child enjoy school |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you satisfied with your child’s school performance? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does child read as well as peer group in school? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does child read as well as brothers and sisters? |

Are there any other factors or further information you feel would be of help to us?

It is often beneficial to discuss examination results with other professionals working with your child. Please sign below to authorize this exchange of information:

Signature **Date**

Relation to child

Thank you for taking the time to complete this rather lengthy questionnaire, the information given will help us to plan the most appropriate tests to use, and prepare us for your appointment!
Please ensure you return it to us at the St Georges Road branch, together with the £50 deposit and teachers questionnaire well ahead of the appointment.