VISION4
Learning . Working . Living

Vision4 – Questionnaire

Name: _____

Gender: ☐ M / F ☐ Class/Grade: ____ / ____ DOB: _____

Last eye examination:

Are spectacles or contact lenses worn? ☐ Y / N ☐

If so, please specify type of correction: _____ (Specs/Contacts)

If correction is worn, please circle the type of use for which they were recommended: ☐ Distance ☐ Near ☐ Constant

Do you have details of the most current prescription? ☐ Y / N ☐

If so, please provide below, or circle copy attached: COPY ATTACHED

R ---------- L ----------

Please complete or tick the appropriate boxes below to indicate relevant history for student's general health, development, eye health, symptoms experienced and family conditions.

Student's General Health

Please detail any significant health history (conditions, surgery, injury, infection, etc...)

Please list any current medications:

Developmental history:

Were there any complications during pregnancy or birth? ☐ Y / N ☐

If Yes, please outline complications or other developmental issues:

Eye Health:

Does your child suffer from:

☐ Eye turn ☐ Lazy eye eye disease/Infection

Other eye conditions:

Symptoms:

Has your child experienced (or have you observed) any of the following:

☐ Distance blur ☐ Near blur ☐ Headaches ☐ Watery eyes

☐ Excessive rubbing/Blinking ☐ Skipping/Repeating words or lines

☐ Difficulty copying from board ☐ Avoidance of near work

☐ Poor attention/Comprehension when reading ☐ Behavioural issue

☐ Noticeable head tilt or covering/Closing one eye

☐ Holds books close ☐ Learning difficulties/Falling behind

Family History:

Please tick the relevant family general or visual conditions:

☐ Spectacles worn ☐ Eye turn ☐ Lazy Eye ☐ Eye disease/Infection

☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Diabetes

☐ Heart disease