Visual History Questionnaire

The following questions provide information on visual history, which helps in putting any reports of current visual difficulties into context.

Questions on eye and vision history	
1. Has your child been prescribed and advised to wear any optical prescription lenses (i.e. glasses or contact lenses)? If YES then : 1a. Are these required for distance vision (e.g. television), near vision (e.g. reading), or both? 1b. Does your child wear their glasses / contact lenses as advised 1c. If YES, please ensure your child has the prescribed glasses/ contact lenses with them on the day.	Yes ☐ No ☐ Distance ☐ Near ☐ Both ☐ Yes ☐ No ☐ If NO, why not?: *Prescribed glasses/ contact lenses should be worn for a SpLD assessment, unless intended for distance only.*
2. When did your child last have an eye test by an optometrist ("optician")?	*A standard sight test must be completed by an optometrist within 24 months prior to the assessment*
3. Has your child ever used coloured overlays or precision-tinted lenses? If YES then : 3a. Who recommended and provided these? 3b. Why were they recommended? 3c. Did they help? — if YES, in what way? 3d. Does your child still use them? — if NO, why not?	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
4. Has your child ever had hospital treatment for a problem with their eyes or vision? For example … — wearing a patch for a 'lazy eye' (amblyopia)? — wearing glasses or having exercises to help correct a 'turn' in their eye (squint)? — any other condition?	Yes ☐ No ☐

Visual Difficulties Questionnaire (VDQ)

The VDQ requests simple yes/no answers to a few questions about symptoms and signs involving FEEL (visual discomfort, Q1-3), SEE (visual disturbance Q4-7), DO (behaviour Q8-9), and one general question (10) about any other experience.

often = persistent, occurring several times a week, though not necessarily every day

Please ask your child these questions:	Yes	No
1. Do you often get headaches when you read or study?	☐	☐
2. Do your eyes often feel sore, or gritty, or watery?	☐	☐
3. Does reading from white paper or from a bright screen often feel uncomfortable?	☐	☐
4. Does print often appear blurred, or go in and out of focus, when you are reading?	☐	☐
5. Does the print, or book, or screen, often appear double when you are reading?	☐	☐
6. Do words often seem to move or merge together when you are reading?	☐	☐
7. Do objects in the distance often appear more blurred after you have been reading?	☐	☐
8. Do you often have to screw up your eyes to see more clearly when you are reading?	☐	☐
9. Do you often move your eyes around or blink to make things clearer or more comfortable when you are reading?	☐	☐
10. Do you experience any other problems with your vision that interfere with your ability to read or study? If YES then describe:	☐	☐

Note the emphasis on the word often in questions 1-9, which is deliberately intended to identify when a symptom occurs frequently. Therefore, the individual should be advised to answer NO if reported symptoms would be considered infrequent (e.g. rarely, occasionally, sometimes, <2-3 times per month).