**Visual History Questionnaire – please complete for yourself or on behalf of your child.**

Visual difficulties that affect an individual’s performance will typically give rise to symptoms of discomfort and visual disturbance, which may result in changes in behaviour as an effect of the symptoms, or as a strategy to cope with the difficulty. These behavioural changes are often helpful signs that the individual is experiencing visual difficulty. Often, though not always, visual difficulties will be exacerbated by tasks involving sustained and intensive reading or studying of visual material.

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

| **QUESTIONS** | **RESPONSES** | **NOTES** |
| --- | --- | --- |
| **1. Have you 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. Do you wear your glasses / contact lenses as advised?****1c. Do you have your glasses / contact lenses with you today?** | Yes / NoDist / Near / BothYes / NoYes / No | If correction prescribed and normally worn for near work, then it should be worn for SpLD assessment |
| **2. How long ago was your last sight-test or eye test by an optometrist (”optician”) — less than two years ago, more than two years, NEVER)?** | < 2 years> 2 yearsNever | see Screening Protocol above for use of the response to this question |
| **3. Have you 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. Do you still use them? — if NO, why not?** | Yes / No |  |
| **4. Have you ever had hospital treatment for a problem with your eyes or vision?**for example …— wearing a patch for a ‘lazy eye’ (amblyopia)?or— wearing glasses or having exercises to help correct a ‘turn’ in your eye (squint)?or— 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.

| **QUESTIONS** | **NO** | **YES** |
| --- | --- | --- |
| **often** = persistent, occurring several times a week, though not necessarily every day |  |  |
| **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).