optometry vision & learning contact lenses

Keith Holland & Associates
27 St George's Road
Cheltenham GL50 3DT
Tel: 01242 233 500
reception@keithholland.co.uk

Adult Pre-Assessment Questionnaire

This questionnaire will allow us tailor your appointment 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

Work Telephone Number

Mobile Number

Fax

Email address

Date of Birth

Who referred you to our practice?

Name and address of G.P

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

Please try to explain your chief concerns that have led you to seek our help:

SECTION 2 – PREVIOUS EYECARE HISTORY

Have you ever had any previous eye care? (please circle) YES / NO

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

If spectacles have been prescribed are they still worn? YES / NO
Do you wear contact lenses YES / NO (*if so, please bring with you, as well as any spectacles you have)*

SECTION 3 - VISUAL SIGNS

Do you experience any of the following? (Please tick as appropriate, if very common use two ticks)

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

SECTION 4 – GENERAL SIGNS

	YES	NO
Difficulty with co-ordination	☐☐	☐
Tendency to trip over a lot	☐☐	☐
Problems with balance	☐☐	☐
Prone to travel sickness	☐☐	☐
Untidy handwriting	☐☐	☐
Discomfort in hand when writing	☐☐	☐
Letter formed backwards in writing	☐☐	☐
Difficulties with spelling	☐☐	☐
Spelling errors generally phonetic	☐☐	☐

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

SECTION 5 – DEVELOPMENTAL HISTORY

Were there any complications before, during or soon after your birth? (Please give details)

SECTION 4 – HEARING

Have you ever had any hearing problems? **YES** / **NO** *If so, please give detail including which ear was involved (if known), and age*

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

Do you respond well to verbal instructions? **YES** / **NO**

Are you easily distracted by sounds? **YES** / **NO**

Very sensitive to background noise? **YES** / **NO**

Prone to daydreaming and 'tuning out' **YES** / **NO**

Confused in 'busy' environments? **YES** / **NO**

SECTION 5 – HEALTH *If yes to any, please give further details below*

Do you have any health problems? **YES** / **NO**

Do you suffer from allergies? **YES** / **NO**

Do you have any nutritional or eating problems? **YES** / **NO**

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 learning difficulty such as; dyslexia, hyperactivity, attention difficulties, autism or speech problems? **YES** / **NO** *If yes please give details*

SECTION 7 – LATERALITY

Are you: (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:** ☐

Do you confuse directions and lefts and rights? **YES** / **NO**

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

SECTION 8 – WORK

What is your occupation?

Please tell us about what your work involves, and any difficulties you may have:

Have any other tests been carried out in the past? (e.g. educational psychologist evaluation) YES / NO

IF 'YES' PLEASE COULD YOU LET US SEE A COPY OF ANY REPORTS THAT HAVE BEEN PREPARED

Have you ever been formally diagnosed with a 'learning difficulty', and if so what diagnosis was given?

What are your interests and hobbies out of work?

Do you drive? YES / NO If yes, do you have any particular problems when driving – please list?

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 you. Please sign below to authorize this exchange of information:

Signature **Date**

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 well ahead of your appointment.