|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Questions on eye and vision history** | | **Comments and notes** | |
| 1 | Have you any history of visual difficulties / problems with sight / visual impairment? | |  | |
| 2 | When did you last have a sight-test by an optometrist (“optician”)? | |  | |
| 3 | Was any prescription made? **YES / NO**  If **YES**, were you advised to wear the prescription glasses/contact lenses for **distance** (e.g. for watching television or for driving) or **near** (e.g. for reading) or **both**?  If **YES**, do you wear the prescribed glasses / contact lenses? **YES / NO**  If **NO**, why not? | |  | |
| 4 | If YES, do you have the prescribed glasses/contact lenses with you today? | | Prescribed glasses/contact lenses should be worn for a SpLD assessment, unless intended for distance use only. | |
| 5 | Have you ever used coloured overlays / colour-tinted glasses? **YES/NO**   If **YES**,  Who advised and provided them?  Why were they recommended?  Did they help? If **YES**, in what way?  Do you still use them? If not, why not? | |  | |
| **Questions on reading / near work activity** | | | | |
| 6 | | Approximately how many hours per working/study day do you spend at a screen (phone, tablet, computer) etc? | |  |
| 7 | | Approximately how many additional hours per working /study day do you spend reading books, newspapers, comics or other paper-based texts? | |  |
| 8 | | Has your screen /reading /near work time increased recently? If so, by how much? | |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Visual Difficulties Questionnaire (post - 16 years)\*** | Never | Rarely | Sometimes | Often | Always |
| 1 | Do you get headaches when you read? |  |  |  |  |  |
| 2 | Does reading make your eyes feel sore, gritty or watery? |  |  |  |  |  |
| 3 | Does reading make you feel tired or sleepy? |  |  |  |  |  |
| 4 | Do you become restless or fidgety or distracted when reading? |  |  |  |  |  |
| 5 | Do you become less comfortable the longer you read? |  |  |  |  |  |
| 6 | When do you prefer dim light to brighter light for reading? |  |  |  |  |  |
| 7 | Does reading from white paper seem too bright or glaring? |  |  |  |  |  |
| 8 | Do parts of the white page between the words form patterns when you read? |  |  |  |  |  |
| 9 | Does the print or background shimmer or appear coloured as you read? |  |  |  |  |  |
| 10 | Does print appear to jitter or move on the page as you read? |  |  |  |  |  |
| 11 | Do you screw your eyes up when reading? |  |  |  |  |  |
| 12 | Do you rub your eyes to relieve the strain when you are reading? |  |  |  |  |  |
| 13 | Do you move your eyes around or blink to keep text clear when you read? |  |  |  |  |  |
| 14 | Do you use a marker or your finger to stop you losing the place when you read? |  |  |  |  |  |
| 15 | Do you cover or close one eye when reading? |  |  |  |  |  |
| 16 | Do you lose your place when reading? |  |  |  |  |  |
| 17 | Do you re-read or skip words or lines when reading? |  |  |  |  |  |
| 18 | Does text appear blurred, or go in and out of focus, when you read? |  |  |  |  |  |
| 19 | Do objects in the distance appear more blurred after you have been reading? |  |  |  |  |  |
| 20 | Do the words, page or book appear double when you are reading? |  |  |  |  |  |
| **\*N.B. Response categories for this protocol: Always = every day. Often = several times a week but not necessarily every day.**  **Sometimes = 2-3 times a month. Rarely = only once every few months / a year.** | | | | | | |