VISUAL EFFICIENCY EVALUATION HISTORY

Child's Name: _____ Birthday: _____/_____/_____ Age: _____

Parent/Guardian(s) Name: _____ Phone: _____

Grade: _____ School Name: _____ Referred by: _____

Please state the major reason you would like your child examined:

_____

_____

Goal(s): _____

_____

Please place a check in the appropriate box.

CISS Survey	Never (0)	Rarely (1)	Occasionally (2)	Frequently (3)	Always (4)
Do your eyes feel tired when reading or doing close work?					
Do your eyes feel uncomfortable when reading or doing close work?					
Do you have headaches when reading or doing close work?					
Do you feel sleepy when reading or doing close work?					
Do you lose concentration when reading or doing close work?					
Do you have trouble remembering what you have read?					
Do you have double vision when reading or doing close work?					
Do you see the words move, jump, swim, or appear to float on the page when reading or doing close work?					
Do you feel like you read slowly?					
Do your eyes ever hurt when reading or doing close work?					
Do your eyes ever feel sore when reading or doing close work?					
Do you feel a "pulling" feeling around your eyes when reading or doing close work?					
Do you notice the words blurring or coming in and out of focus when reading or doing close work?					
Do you lose your place while reading or doing close work?					
Do you have to re-read the same line of words when reading					
Total Score					

Vision	No	Yes	If yes, please explain:
Does your child currently wear glasses?			FULL TIME/ DISTANCE ONLY/NEAR ONLY
Has your child ever worn glasses?			
Has your child ever worn contact lenses?			
Any history of patching?			
Any history of optometric vision therapy?			
Does your child have an eye turn?			
Does your child have blurry vision in the distance?			

Behavior	Never	Rarely	Occasionally	Frequently	Always
Hyperactive					
Easily frustrated					
Easily fatigued					
Awkward or clumsy					
Behavior or emotional problems at home or school					
Reverses letters, words, or numbers in reading/writing					
Shows confusion about right or left					

Health History	No	Yes	If yes, please explain:
Any diagnosed visual problem?			Date of last eye exam:
Any diagnosed health problem?			Date of last physical exam:
Any family history of learning difficulties?			
Any history of eye surgery?			
Any history of head trauma?			Loss of consciousness?
Any medications and/or vitamins?			Please list, including purpose, dosage, duration of treatment:
History of previous (or current) therapy for learning, visual, occupational, physical, and/or speech difficulties?			Please list, including type of therapy, duration, and results:

Pregnancy and Birth History	No	Yes	Comments:
Complications during pregnancy or delivery?			
Normal gestation time?			If premature, number of weeks?
Normal birth weight?			lbs. oz.

Developmental Milestones	No	Yes	If no, when?
Said first word at 12 months			
Used sentences of more than 3 words by age 4 years			
Walked unaided by 18 months			
Grasped a crayon between thumb and finger by age 4 years			

Education	No	Yes	If yes, please explain:
Does your child have an IEP?			
Does your child receive any accommodations in school?			Please list, including type of therapy, duration, and results:
Any history of neurological evaluation?			
Does your child enjoy school?			Favorite subject? Most difficult subject?
Has any grade been repeated?			If so, which grade and why?
Do you feel your child is achieving up to their potential?			