Visual Difficulties Screening Protocol V.2. 2019: adults

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? YES	Prescribed glasses/contact lenses should be worn for a SpLD assessment, unless intended for
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?	
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 are reading?					
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.						

Visual Difficulties Screening Protocol V.2. 2019: children

Questions on eye and vision history	Comments and notes
1. Has your child 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, was your child 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, does your child wear the prescribed glasses / contact lenses? YES / NO If NO, why not?	
4. If YES, does your child have the prescribed glasses/contact lenses with them today? YES / NO	Prescribed glasses/contact lenses should be worn for a SpLD assessment, unless intended for distance use only.
5. Has your child 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?	
Questions on reading / near work activity	
6. Approximately how many hours per school day does your child spend at a screen (phone, tablet, computer) etc?	
7. Approximately how many additional hours per school day does your child spend reading books, newspapers, comics or other paper-based texts?	
8. Has your child’s screen /reading /near work time increased recently? If so, by how much?	

	Visual Difficulties Questionnaire (pre - 16 years)*	Never	Rarely	Sometimes	Often	Always
	Section for parents/carers					
1	Does your child report headaches when they are reading?					
2	Does your child report that reading makes their eyes feel sore, gritty or watery?					
3	Does your child report feeling tired or sleepy during or after reading?					
4	Have you noticed your child become restless, fidgety or distracted when reading?					
5	Have you noticed your child rubbing their eyes when they are reading?					
6	Have you noticed your child screwing up their eyes when reading?					
7	Have you noticed your child tilting their head to one side when reading?					
8	Have you noticed your child moving their eyes around or blinking frequently when they are reading?					
9	Have you noticed your child holding a paper or book very close to their eyes when reading?					
10	How often does your child use a marker or their finger to keep their place when reading?					
11	Have you noticed that your child frequently loses their place when reading?					
12	Have you noticed your child covering or closing one eye when reading?					
	Section for child					
13	When you read, do you see two of each word?					
14	When you read, do the words you read look blurry (or fuzzy, or unclear)?					
15	When you are reading, do the words move on the page?					
16	When your teachers ask you to copy something from a screen at the front of the classroom, can you see what is written on the screen?					

*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.