

# TEACHER'S QUESTIONNAIRE FOR LEARNING-RELATED VISION PROBLEMS

Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
Completed By: \_\_\_\_\_ Position: \_\_\_\_\_ Phone: \_\_\_\_\_  
School: \_\_\_\_\_

The child's parent or guardian requests that you assist the doctor by providing information based on your experience working with the child. Your responses will contribute to the doctor's evaluation of a potential vision problem that impacts reading or schoolwork. Please check any of the following that apply to this child. Thank you.

- Short attention span, easily distracted, or extensive daydreaming
- School performance not up to potential
- Reading below grade level
- Had special education testing or receives special education services
- Poor reading comprehension
- Difficulty with word recognition
- Reversals (b for d, p for q, was - saw, on - no) when reading or writing
- Transposition of letters or numbers (21 for 12)
- Failure to complete work in allotted time
- Errors in copying from blackboard to paper
- Poor printing or handwriting
- Mistakes words with similar beginnings or endings
- Confuses similar words
- Fails to recognize same word in next sentence
- Uses finger or marker to keep place when reading
- Often loses place, skips or rereads words and/or letters when reading
- Complains of blurred vision during reading or writing, or when looking up from desk
- Complains of headaches associated with visual tasks
- Complains of print moving around or running together
- Complains of seeing double
- Closes or covers one eye
- Experiences unusual fatigue after visual concentration
- Reports eyes hurt, burn, or tire while reading
- Experiences rubbing, blinking, or tearing of eyes
- Squints or frowns when doing visual work closer than arm's length away
- Tilts or turns head excessively when doing visual tasks
- Avoids near work such as reading, writing or written math problems

Please comment on this child's performance in school (use separate sheet if needed) \_\_\_\_\_

\_\_\_\_\_  
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May we contact you with additional questions? \_\_\_\_\_ Best time to reach you: \_\_\_\_\_

*Please fax or mail completed form to:* (570) 546-0628 fax (570) 546-4885 phone  
Vision & Learning Center of Northcentral PA Marcus Myers, O.D. 112 S. Main St., Muncy PA 17756