



VISUAL CASE HISTORY - TEACHER'S OBSERVATIONS

Child's Name: Mast/Miss _____ Date: _____
(First Name) (Surname)
School: _____ Grade: _____ Teacher: _____

Our Patient ID: _____

I request and grant permission for the release of this information to my child's optometrist at Eyecare Plus.

(Signed by parent/guardian) _____

THIS INFORMATION IS CONFIDENTIAL

INTRODUCTION:

Following is a checklist of symptoms which have been found to be often associated with a vision problem. We realise that all these items may not apply to this student, or that you may not have had the opportunity to observe some of the items.

OBSERVATIONS:

Does this student display any of the following?

- 1. Complains of headaches: Y N When _____ How often _____
- 2. Complains of sore, red, watery eyes: Y N When _____ How often _____
- 3. Complains of seeing double: Y N _____
- 4. Complains of blurry books or blackboard: Y N _____
- 5. Words or letters that run together: Y N _____
- 6. Letters move on the page or board: Y N _____
- 7. Likes to read, or avoids it: Y N _____
- 8. Short attention span (for age) with reading or writing: Y N _____
- 9. Loses place, skips words or lines: Y N _____
- 10. Uses a finger or marker to keep place: Y N _____
- 11. Holds work close to face when reading or writing: Y N _____
- 12. Slow or poor copier from board to books: Y N _____
- 13. Clumsy or poorly coordinated: Y N _____
- 14. Confuses right and left hands, or reverses letters or numbers: Y N _____
- 15. Is this student in the lower 1/3 of the class? Y N _____
- 16. What are the best subjects? _____
- 17. What are the poorest subjects? _____
- 18. In your opinion, does this student have the ability to achieve above the present level? Y N _____

Any other impressions, special help found effective, other pertinent observations or unusual characteristics of this student:

Signed: _____
(Teacher)