Pediatric Vertical Heterophoria Symptom Questionnaire (P-VHSQ-I&A)

(Initial and Annual) for children 17 years old and younger

Vision Specialists of Michigan

2550 S. Telegraph Road, Suite 100 www.VSofM.com	Bloomfield Hills, Michigan 4830		(248) 258-9000 Fax (248) 499-6372			
Name:	Email:	Da	ite:			
Best phone number:	Back-up phone numbe	r:				
For every question, check the answer you wear glasses or contact lenses, a are wearing them.	e questions together with your Parents er that best describes your situation. I answer the questions assuming that yo	ſſ	NALLY	VTLY		
Never Occasionally = Le Frequently = A Always	✓ NEVER	✓ OCCASIONALLY	✓ FREQUENTLY	✓ ALWAYS		
1. Do you have headaches or face pair	n?					
2. Do your eyes hurt and/or does it hurt to move your eyes?						
3. Do you have neck pain or a stiff neck or upper back pain?						
4. Do you have stomach aches or nau	sea?					
5. Do you get car sickness or motion s	sickness?					
6. Did you get sick in the car seat whe	en you were a small child?					
7. Do you get sick to your stomach or	nauseous on swings or circular rides?					
8. Does riding in the car give you head	daches or stomach aches?					
9. Do you have trouble reading in the	car?					
10. Do you feel clumsy or klutzy or un	acoordinated?					
11. When you are walking, do you but frames?	mp into people or furniture or door					
12. Do you feel funny or dizzy when y	ou bend over and stand back up quickly	?				
13. Are you anxious or nervous?						
14. In grocery stores or malls, do you (Do you feel uncomfortable in grocery	stay close (cling) to your Mom or Dad? stores or malls?)					
15. Do you tend to play alone or with j play apart from the main group of kid						
16. Is reading hard for you or are you	a slow reader?					
17. Do you have to read the same thin it?	g a couple of times to really understand					

	Г							
		✓ NEVER	✓ CCASIONALLY	✓ FREQUENTLY	✓ ALWAYS			
18. Do you use your finger or a ruler or a piece of paper to help you keep your place when you are reading?								
19. Do you skip lines or lose your place when you are reading?								
20. When you read, does it look like the letters are moving OR does it seem like words are bumping into each other?								
21. Do bright lights hurt your eyes?								
22. Do you close or cover one eye to make it easier to see?								
23. Do you have trouble catching baseballs or footballs or Frisbees?								
24. Do you ever see two of everything (double vision)?								
25. Is it hard for you to watch 3-D movies?								
26. When reading or working on the computer, do your eyes feel tired or does your vision get blurry?								
27. When looking at the blackboard at school, do your eyes feel tired or does your vision get blurry?								
Mom / Dad: Has your child ever been diagnosed with:								
Learning disability (LD)?	NO Reading disability?		YES		0			
Dyslexia?	NO ADD / ADHD?		YES		0			
Torticollis?	NO Migraines or headache disorder?		YES		C			
Lazy eye? 🛛 🗆 YES 🗔 I	NO Traumatic brain injury or concussion	n? □	YES		C			
Does your child blink their eyes a lot / much more then most children?								
Are your child's verbal skills far ahead of their reading skills? □ YES □ NO								
Has your child ever had an eye operation?								
On an average day, how much are you bothered by the 8 symptoms listed below? (Rate each symptom from 0 to 10, where 10 is the worst it could be, and where 0 means you have none of that symptom) Please record any additional symptoms you may be experiencing, or specific concerns that you have about your eyes / vision:								
Dizziness = / 10								
Nausea = / 10								
Anxiety = / 10								
Headache = / 10								
Neckache = / 10								
Unsteady with walking= / 10								
Sensitivity to light = $/10$ Reading difficulty = $/10$	© 2004-2012 Vision Specialists of Michigan Form	010212	2					