REAL EYES OPTOMETRY

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Last Name:_____ First Name:_____

Age: _____ Date: _____

1. **Appearance of the Eyes**

- ☐ One eye turns in, out, up or down at any time
- ☐ Reddened eyes of eyelids
- ☐ Eyes tear excessively
- ☐ Blinks excessively
- ☐ Rubs eyes frequently during or after short periods of visual activity

2. Behavorial Signs of Visual Problems:

- ☐ Squints, closes or covers one eye
- ☐ Tilts head while doing activities that are near (50cm away from eyes)
- ☐ Feels objects rather than looking at objects
- ☐ Avoids looking at books and puzzles, prefers toys they can handle
- ☐ Holds books too close to face of face too close to desk surface
- ☐ Sits very close to the TV (when repeatedly moved back)
- ☐ Coloring: cannot stay within the lines (age dependent) of ignores the lines when coloring

3. **Other Signs/ Problems Noted**

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COMPLETED BY:
Parent / Teacher/ Other

_____ _____

Print Name Signature