BVD SCREENING TEST

Binocular Vision Dysfunction Questionnaire (BVDQ™)

DAU FAMILY EYE CARE

Take the test online!

Name _____ Date _____

Phone Number _____ Email _____

FOR AGES 4-8

Directions: ***Children - answer these questions together with your Parent/Guardian.*** For every question, please answer YES or NO. If you wear glasses, answer the questions assuming that you are wearing them.

DOES YOUR CHILD:		**YES**	**NO**
A	have difficulty reading or learning **OR** skip letters or words or lines **OR** misread words or reverse numbers or words **OR** lose their place often while reading?		
B	have poor handwriting – poor letter sizing (too big or too small), poor spacing, writing lines with an upward or downward slant?		
C	avoid near activities **OR** do they act out after 5-10 minutes if they must perform near activities?		
D	sit very close to the TV / monitor / electronic devices **OR** hold toys very close to their face to see them?		
E	have difficulty identifying shapes, colors, letters, numbers and common images that are age appropriate?		
F	walk with difficulty (do they sway, trip or fall **OR** bump into objects or people) **OR** avoid climbing on furniture or outdoor playscapes?		
G	have trouble seeing the board, or seeing up close?		
H	have difficulty catching or kicking a ball?		
I	have headaches or stomach aches at school, pre-school or when away from home?		
J	have light sensitivity (closes/covers eyes in bright light) **OR** not like bright places?		
K	close or cover one eye when doing up close activities?		
L	have nervousness or anxiety **OR** get startled often **OR** is clingy in stores?		
M	squint or blink or make faces to “see”?		
	TOTALS		

Parent/Guardian: Has your child ever been diagnosed with:

	YES	NO		YES	NO
Learning Disability (LD)?			Migraines or headache?		
Dyslexia?			Traumatic brain injury or concussion?		
Torticollis?			Does your child blink his/her eyes a lot/much more than most children?		
Lazy eye?			Are your child's verbal skills far ahead of his/her reading skills?		
ADD/ADHD?			Has your child ever had an eye operation?		

On an average day, how much are you bothered by symptoms listed here?

Rate each symptom from 0 -10
0 = None of that symptom
10 = Worst

	None										Worst
Dizziness	0	1	2	3	4	5	6	7	8	9	10
Nausea	0	1	2	3	4	5	6	7	8	9	10
Anxiety	0	1	2	3	4	5	6	7	8	9	10
Headache	0	1	2	3	4	5	6	7	8	9	10

	None										Worst
Neckache	0	1	2	3	4	5	6	7	8	9	10
Unsteady when walking	0	1	2	3	4	5	6	7	8	9	10
Sensitivity to light	0	1	2	3	4	5	6	7	8	9	10
Reading difficulty	0	1	2	3	4	5	6	7	8	9	10
Sound sensitivity	0	1	2	3	4	5	6	7	8	9	10

This questionnaire is designed to screen for children who may be having symptoms due to a vision misalignment.

If your 4 or or more of the questions A through M were answered YES, schedule an appointment today.

Treatment is low cost and uses microprism lenses, and if indicated, noise cancelling devices. The average patient requires two appointments and two sets of lenses over 6-8 weeks, and can expect to experience an **80% reduction of symptoms**.

Connect with a scheduler today:

SCAN TO CALL

CALL / TEXT

(904) 713-2020

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This questionnaire is designed to screen for those who may have difficulty with vision alignment. The information obtained herein is considered a preliminary result only and does not diagnose or constitute confirmation of any vision problems. It is not a substitute for a NeuroVisual examination. Since vision changes can occur without visible indications, most eye care professionals and medical authorities recommend a vision exam annually.