Quality of Life

PATIENT'S NAME: _____ DATE: _____

Check the column that best represents the occurrence of each symptom. Completed by: _____

	NEVER	SELDOM	OCCASIONALLY	FREQUENTLY	ALWAYS
1. Blur when looking at near	☐	☐	☐	☐	☐
2. Double vision	☐	☐	☐	☐	☐
3. Headaches with near work	☐	☐	☐	☐	☐
4. Words run together when reading	☐	☐	☐	☐	☐
5. Burning, itching, watery eyes	☐	☐	☐	☐	☐
6. Falls asleep when reading	☐	☐	☐	☐	☐
7. Sees worse at the end of the day	☐	☐	☐	☐	☐
8. Skips/repeats lines when reading	☐	☐	☐	☐	☐
9. Dizzy/nausea with near work	☐	☐	☐	☐	☐
10. Head tilt/close one eye when reading	☐	☐	☐	☐	☐
11. Difficulty copying from the chalkboard	☐	☐	☐	☐	☐
12. Avoids near work/reading	☐	☐	☐	☐	☐
13. Omits small words when reading	☐	☐	☐	☐	☐
14. Writes up/down hill	☐	☐	☐	☐	☐
15. Misaligns digits/columns of numbers	☐	☐	☐	☐	☐
16. Poor reading comprehension	☐	☐	☐	☐	☐
17. Poor/inconsistent in sports	☐	☐	☐	☐	☐
18. Holds reading too close	☐	☐	☐	☐	☐
19. Trouble keeping attention on reading	☐	☐	☐	☐	☐
20. Difficulty completing assignments on time	☐	☐	☐	☐	☐
21. Says "I can't" before trying	☐	☐	☐	☐	☐
22. Avoids participating in sports/games	☐	☐	☐	☐	☐
23. Poor handwriting / hand-eye coordination	☐	☐	☐	☐	☐
24. Does not judge distance accurately	☐	☐	☐	☐	☐
25. Clumsy or knocks over things	☐	☐	☐	☐	☐
26. Does not use time well	☐	☐	☐	☐	☐
27. Resistant to change	☐	☐	☐	☐	☐
28. Loses belongings/things	☐	☐	☐	☐	☐
29. Car/motion sickness	☐	☐	☐	☐	☐
30. Forgetful/poor memory	☐	☐	☐	☐	☐
	___x 0	___x 1	___x 2	___x 3	___x 4

Click Below to Submit Form!

(For in office use) Total _____