PEDIATRIC VISION DEVELOPMENT CENTER

NAME: _____ DOB: ____ /____ /_____ DATE: ____ /____ /_____

VISUAL QUESTIONNAIRE

Instructions: Ask the following questions exactly as written. If the patient responds "yes" – please qualify the frequency choices. Do not give examples.

Patient Instructions: Please answer the following questions about how your eyes feel when reading or doing close work.

		Frequency				
	Possible Subjective Symptoms	Never (0)	Infrequently/ Not very often (1)	Sometimes (2)	Fairly Often (3)	Always (4)
1.	Do your eyes feel tired when reading or doing close work?					
2.	Do your eyes feel uncomfortable when reading or doing close work?					
3.	Do you have headaches when reading or doing close work?					
4.	Do you feel sleepy when reading or doing close work?					
5.	Do you lose concentration when reading or doing close work?					
6.	Do you have troubles remembering what you have read?					
7.	Do you have double vision when reading or doing close work?					
8.	Do you see the words move, jump, swim or appear to float on the page when reading or doing close work?					
9.	Do you feel like you read slowly?					
10.	Do your eyes ever hurt when reading or doing close work?					
11.	Do your eyes ever feel sore when reading or doing close work?					
12.	Do you feel a "pulling" feeling around your eyes when reading or doing close work?					
13.	Do you notice words blurring or coming in and out of focus when reading or doing close work?					
14.	Do you lose your place when reading or doing close work?					
	Total Score					
15.	Do you notice one eye that turns In / Out / Up / Down (circle one)					
16.	Blurry vision in the distance after prolonged near work?					
17.	Closes one eye when reading or doing close work?					
18.	Omits words when reading?					
19.	Fills in the wrong bubbles on a computer graded test?					
20.	Misaligns or misplaces numbers in columns?					
21.	Poor handwriting, or writes uphill or downhill?					
22.	Difficulty copying from the board at school?					
23.	Writes letters and/or numbers backwards?					
24.	Inconsistent performance in school?					
25.	Inconsistent or poor at sports?					
26.	Persistent difficulty learning to spell?					
	Total Score					

1. What are your/ parent's/ guardian's goals in vision therapy? _____

_____

_____

2. Are there any considerations in your participating in vision therapy that you would like us to be aware? ____ Yes ____ No

If yes, please explain (e.g., time availability, behavioral or physical limitations, etc) _____

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