Binocular Vision Symptom Survey

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

NOTE: If the patient is a child, please read the instructions and then each item exactly as written. If the patient responds with "yes" please qualify with frequency choices. Do not give examples.

With young children it may help to use your observations and experience with them to get an alternate score for comparison.

	Never	Not very often-Infrequently	Sometimes	Fairly often	Always
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 your feel sleepy when reading or doing close work?	☐	☐	☐	☐	☐
5. Do you lose concentration when reading or doing close work?	☐	☐	☐	☐	☐
6. Do you have trouble 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 the 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?	☐	☐	☐	☐	☐
15. Do you have to reread the same line of words when reading?	☐	☐	☐	☐	☐
Multiply the number of items marked per column by the number indicated for a column score:	___ X 0 = 0	___ x 1 = ___	___ x 2 = ___	___ x 3 = ___	___ x 4 = ___

Next Add each for a *Total Score* _____

A total score of 16 or more indicates the need for a binocular vision evaluation.