QUALITY OF LIFE SYMPTOM CHECKLIST*

Check the column that best represents the occurrence of each symptom.

Patient's Name: ______________________________

Date: ______________________________

		0 Never	1 Seldom	2 Occasionally	3 Frequently	4 Always
1	Blur when looking at near					
2	Double vision					
3	Headaches with near work					
4	Words run together when reading					
5	Burning, itchy, watery eyes					
6	Falls asleep reading					
7	Sees worse at the end of the day					
8	Skips/repeats lines when reading					
9	Dizziness/nausea with near work					
10	Head tilt/closing one eye when reading					
11	Difficulty copying from chalkboard					
12	Avoids near work/reading					
13	Omits small words when reading					
14	Writes uphill/downhill					
15	Misaligns digits/columns of numbers					
16	Reading comprehension down					
17	Poor/inconsistent in sports					
18	Holds reading too close					
19	Trouble keeping attention on reading					
20	Difficulty completing assignments on time					
21	Always says "I can't" before trying					
22	Avoids sports/games					
23	Poor hand-eye (poor handwriting)					
24	Does not judge distance accurately					
25	Clumsy, knocks things over					
26	Does not use his/her time well					
27	Does not make change well					
28	Loses belongings/things					
29	Car/motion sickness					
30	Forgetful/poor memory					
	TOTAL					

Add up the total points: Below 15 routine eye care exam; 16-24 visual functional problem referral needed to a developmental optometrist; >25 refer for developmental vision evaluation.

*Checklist is from the College of Optometrists in Vision Development www.covd.org