Vision Symptom Survey

Patient Name:_____ **Date** _____

INSTRUCTIONS: Please check the most appropriate box, or circle the item number that best matches your symptoms today.

Please rate each symptom. **How often does each occur?** (circle a number)	Never	Seldom	Occasionaly	Frequently	Always
EYESIGHT CLARITY					
Distance vision blurred (Not clear with or without lenses)	0	1	2	3	4
Near vision blurred (Not clear with or without lenses)	0	1	2	3	4
Clarity of vision changes or fluctuates during the day	0	1	2	3	4
Poor night vision / can't see well enough to drive at night	0	1	2	3	4
VISUAL COMFORT					
Eye discomfort / sore eyes / eyestrain	0	1	2	3	4
Headaches, dizziness or motionsickness	0	1	2	3	4
Eye fatigue (Very tired after using eyes all day)	0	1	2	3	4
Feel "pulling" around the eyes	0	1	2	3	4
DOUBLING					
Double vision (Especially when tired)	0	1	2	3	4
Have to close or cover one eye to see clearly	0	1	2	3	4
LIGHT SENSITIVITY					
Normal indoor lighting is uncomfortable (Too much glare)	0	1	2	3	4
Outdoor light too bright (Have to use sunglasses)	0	1	2	3	4
Indoors fluorescent lighting is bothersome or annoying	0	1	2	3	4
Sensitivity to computer monitors and digital TV screens	0	1	2	3	4
DRY EYES					
Eyes feel "dry" and sting	0	1	2	3	4
"Stare" into space without blinking	0	1	2	3	4
Have to rub the eyes a lot	0	1	2	3	4

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Please rate each symptom. **How often does each occur?** (circle a number)	Never	Seldom	Occasionaly	Frequently	Always
DEPTH PERCEPTION					
Clumsiness / misjudge where objects really are	0	1	2	3	4
Lack of confidence walking / missing steps / stumbling	0	1	2	3	4
Poor handwriting (spacing, size, legibility)	0	1	2	3	4
PERIPHERAL VISION					
Side vision distorted / objects move or change position	0	1	2	3	4
What looks straight ahead isn't always straight ahead	0	1	2	3	4
Avoid crowds / can't tolerate "visually-busy" places	0	1	2	3	4
Difficulties with balance and movement	0	1	2	3	4
READING					
Short attention span/easily distracted when reading	0	1	2	3	4
Difficulty / slowness with reading and writing	0	1	2	3	4
Poor reading comprehension/can't remember what was read	0	1	2	3	4
Confusion of words / skip words during reading	0	1	2	3	4
Lose place/use finger not to lose place when reading	0	1	2	3	4
Print moves in and out of focus when reading	0	1	2	3	4
Words move on the page	0	1	2	3	4
VISUAL FUNCTION					
Difficulty making sense out of visual information	0	1	2	3	4
Confusion between left and right	0	1	2	3	4
Difficulty finding things often easily located by others	0	1	2	3	4

For internal use only:

A score of 32 or higher indicates the need for a Neuro-Optometric Vision Evaluation.

Peripheral vision symptoms that are a 3 or 4 indicates the need for an immediate referral.