Quality of Life Symptom Checklist

Name: _____Date of Birth:_____

Appointment Date: _____

Please circle how often each symptom occurs based on the given scale:

0 = never or non-existent
1 = seldom
2 = occasionally
3 = frequently
4 = always

1	Blurred vision at near	0	1	2	3	4
2	Double vision	0	1	2	3	4
3	Headaches associated with near work	0	1	2	3	4
4	Words run together when reading	0	1	2	3	4
5	Burning, stinging, or watery eyes	0	1	2	3	4
6	Falling asleep when reading	0	1	2	3	4
7	Vision worse at the end of the day	0	1	2	3	4
8	Skipping or repeating lines when reading	0	1	2	3	4
9	Dizziness or nausea associated with near work	0	1	2	3	4
10	Head tilt or closing one eye when reading	0	1	2	3	4
1 1	Difficulty copying from the whiteboard	0	1	2	3	4
12	A voidance of reading and near work	0	1	2	3	4

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13	Omitting small words when reading	0	1	2	3	4
14	Writing uphill or downhill	0	1	2	3	4
15	Mis-aligning digits in columns of numbers	0	1	2	3	4
16	Reading comprehension declining over time	0	1	2	3	4
17	Inconsistent / poor sports performance	0	1	2	3	4
18	Holding reading material too close to eyes	0	1	2	3	4
19	Short attention span	0	1	2	3	4
20	Difficulty completing assignments in reasonable time	0	1	2	3	4
21	Saying "I can't" before trying	0	1	2	3	4
22	A voiding sports and games	0	1	2	3	4
23	Difficulty with hand tools-scissors, calculators, keys, etc.	0	1	2	3	4
24	Inability to estimate distances accurately	0	1	2	3	4
25	Tendency to knock things over on desk or table	0	1	2	3	4
26	Difficulty with time management	0	1	2	3	4
27	Difficulty with money concepts (making change)	0	1	2	3	4
28	Misplaces or loses papers, objects, belongings	0	1	2	3	4
29	Car sickness / motion sickness	0	1	2	3	4
30	Forgetful, poor memory	0	1	2	3	4