COVD Quality of Life
Visual Symptom Survey

Name _____ **Date** _____ **Age**_____

Indicate below how often the following symptoms are experienced by you or your child.

	Never	Seldom	Sometimes	Frequently	Always
1. *Headaches* or Eyes *feel tired, uncomfortable, sore, or hurt, or have a "pulling" sensation* when doing near work?	0	1	2	3	4
2. *Words move, jump, swim, appear to float, or run together* on the page when reading?	0	1	2	3	4
3. *Burning, itching, or watery eyes?*	0	1	2	3	4
4. *Skip or repeat lines* when you read?	0	1	2	3	4
5. *Tilt your head, or close/cover an eye* when doing near work?	0	1	2	3	4
6. *Difficulty copying from the whiteboard?*	0	1	2	3	4
7. *Avoids near work* such as reading/writing?	0	1	2	3	4
8. *Omits (drop out) small words* when doing near work?	0	1	2	3	4
9. *Writes uphill/downhill* when writing?	0	1	2	3	4
10. *Misaligns* digits/columns of numbers?	0	1	2	3	4
11. *Trouble remembering* what you read (poor reading comprehension)?	0	1	2	3	4
12. *Holds books or near work very close* to eyes?	0	1	2	3	4
13. *Short attention span or lose focus* when doing near work?	0	1	2	3	4
14. *Difficulty finishing assignments* or tasks in reasonable time?	0	1	2	3	4
15. *First response "I Can't"* before trying something?	0	1	2	3	4
16. *Clumsiness* and knocking things over?	0	1	2	3	4
17. Poor use of time	0	1	2	3	4
18. *Lose belongings* or misplace things?	0	1	2	3	4
19. Forgetting things	0	1	2	3	4

A Score of ≥ 21 is strongly suggestive of a vision problem.

For office use only

Totals *(Add columns together)*					
Total Score *(Sum of Columns)*					