

Quality of Life Checklist

Check the column which best represents the occurrence of each symptom	Never 0	Seldom 1	Occasionally 2	Frequently 3	Always 4
Blurred close vision	☐	☐	☐	☐	☐
Double vision	☐	☐	☐	☐	☐
Headaches with near work	☐	☐	☐	☐	☐
Words run together reading	☐	☐	☐	☐	☐
Burning, itchy, watery eyes	☐	☐	☐	☐	☐
Falls asleep reading	☐	☐	☐	☐	☐
Sees worse at the end of day	☐	☐	☐	☐	☐
Skips/repeats lines reading	☐	☐	☐	☐	☐
Dizzy/nauseated by near work	☐	☐	☐	☐	☐
Head tilt/one eye closed to read	☐	☐	☐	☐	☐
Difficulty copying from chalkboard	☐	☐	☐	☐	☐
Avoids near work/reading	☐	☐	☐	☐	☐
Omits small words when reading	☐	☐	☐	☐	☐
Writes uphill/downhill	☐	☐	☐	☐	☐
Misaligns digits/columns of numbers	☐	☐	☐	☐	☐
Poor reading comprehension	☐	☐	☐	☐	☐
Poor/inconsistent in sports	☐	☐	☐	☐	☐
Holds reading too close	☐	☐	☐	☐	☐
Trouble keeping attention on reading	☐	☐	☐	☐	☐
Difficulty completing work on time	☐	☐	☐	☐	☐
Says "I can't" before trying	☐	☐	☐	☐	☐
Avoids sports/games	☐	☐	☐	☐	☐
Poor hand/eye coordination	☐	☐	☐	☐	☐
Poor handwriting	☐	☐	☐	☐	☐
Does not judge distance accurately	☐	☐	☐	☐	☐
Clumsy, knocks things over	☐	☐	☐	☐	☐
Poor time use/management	☐	☐	☐	☐	☐
Does not make change well	☐	☐	☐	☐	☐
Loses things/belongings	☐	☐	☐	☐	☐
Car or motion sickness	☐	☐	☐	☐	☐
Forgetfulness/poor memory	☐	☐	☐	☐	☐
Total for each column:	___ x 0 = 0	___ x 1 = ___	___ x 2 = ___	___ x 3 = ___	___ x 4 = ___

Grand Total: 0



<15 = Routine eye exam recommended

16-24 = Comprehensive exam
with developmental OD
recommended

>25 = Developmental vision problem likely,
comprehensive exam with developmental OD
strongly recommended

Submit Form

If the button does not work, save your completed form and attach it to an email to vt@eyehealthcentre.ca