College of Optometrists in Vision Development
Prevention • Enhancement • Rehabilitation

Quality of Life Checklist

Patient Name: _____

Form Completed by: _____

Date: _____

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	___x1 =___	___x2 =___	___x3 =___	___x4 =___
Grand Total:					

<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

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