

## Quality of Life – Symptom Checklist (Adult)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

INSTRUCTIONS: Check the column which best represents the occurrence of each symptom:

	Never	Once in a long while	Sometimes	A lot	Always
Fatigue easily with reading					
Avoid near tasks					
Eye turn					
Squint, close, or cover an eye					
Difficulty tracking moving objects					
Short attention span					
Make errors copying					
Writing is crooked or poorly spaced					
Poor spelling					
Confusion of left and right					
Confuse or reverse letters, numbers, or words					
Dizziness with near tasks					
Eyes bothered by light					
Carsickness					
Eyes hurt or tired after near work					
Face too close to paper when reading or writing					
Print runs together or words jump when reading					
Print moves or goes in and out of focus when reading					
Headaches, nausea, or discomfort when viewing 3D					
Unable to appreciate depth in 3D					
Frequent head movement when reading					
Head turn or tilt when reading or writing					

	Never	Once in a long while	Sometimes	A lot	Always
Double vision					
Skip lines or lose place when reading or copying					
Re-read or omit words or lines when reading					
Difficulty using binoculars					
Discomfort in crowded areas					
Difficulty judging distances accurately					
Poor eye-hand coordination/poor handwriting					
	x0 ____	x1 ____	x2 ____	x3 ____	x4 ____

TOTAL SCORE: \_\_\_\_\_

Please list any symptoms not included in the checklist: