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COVD Quality of Life Checklist

PATIENT: ______________________________ DATE: ________________________

Check the column which best represents the occurrence of **each** symptom

Category	Symptom	Never (0)	Seldom(1)	Occas.(2)	Freq.(3)	Always(4)
A	Blur when looking at near					
A	Headaches with near work					
A	Sees worse at end of the day					
A	Difficulty copying from the Chalkboard					
A	Avoids near work/reading					
A	Holds head too close to the page					
B	Has double vision					
B	Words run together while reading					
B	Eyes burn, itch, or seem watery					
B	Falls asleep while reading					
B	Closes one eye or tilts head while reading					
OR	Dizzy or nauseous with near work					
OR	Writes up or down hill					
OR	Poor/inconsistent in sports					
OR	Avoids sports/games					
OR	Poor hand-eye coordination/poor handwriting					
OR	Clumsy/knocks things over					
OR	Car/motion sickness					
OM	Skips or repeats lines when reading					
OM	Misaligns digits/columns of numbers					
P	Reading comprehension is poor					
P	Trouble keeping attention on reading					
P	Says “I can’t” before trying					
P	Does not use his/her time well					
P	Does not make change well with money					
P	Loses belongings/things					
P	Forgetful/poor memory					
ALL	Difficulty completing assignments on time					
ALL	Does not judge distance accurately					

Total Score: _______________

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Scores over **16** = Recommend Binocular Exam