Quality of Life Questionnaire

Name: _____ Date: _____

Please assign a value between 0 and 4 for each symptom:
0=never or nonexistent; 1=seldom; 2=occasionally; 3=frequently; 4=always

Item	Category	Symptom
1	S	_____Blurred vision at near
2	S	_____Double vision
3	S	_____Headaches associated with near work
4	S	_____Words run together when reading
5	S	_____Burning, stinging, watery eyes
6	S	_____Falling asleep when reading
7	S	_____Vision worse at the end of the day
8	S	_____Dizziness or nausea associated with near work
9	S	_____Car sickness/motion sickness
10	PO	_____Skipping or reading lines when reading
11	PO	_____Head tilt or close eye when reading
12	PO	_____Difficulty copying from the chalk board, shifting from distance to near
13	PO	_____Avoidance of reading near work
14	PO	_____Omitting small words when reading
15	PO	_____Writing uphill or downhill
16	PO	_____Misaligning digits in columns of numbers
17	PO	_____Reading comprehension declining over time
18	PO	_____Holding reading material too close
19	PO	_____Difficulty with hand tools, scissors, screwdriver, calculator, keys
20	PO	_____Inability to estimate distance accurately
21	PO	_____Tendency to knock things over on desk or table
22	SI	_____Inconsistent/poor in sports performance
23	SI	_____Avoiding sports and games
24	SI	_____Difficulty completing assignment in time
25	SI	_____Difficulty with time management
26	SI	_____Difficulty with money concepts, making change
27	P	_____Short attention span
28	P	_____Saying “I can’t” before trying
29	P	_____Misplaces or loses papers, objects, belongings
30	P	_____Forgetful, poor memory

Total= _____/120 S=_____/36 PO=_____/48 SI=_____/20 P=_____/16

S=Somatic Sensation PO=Physical/Occupational SI=Social Interaction P=Psychological