VISIONARY
EYE CARE

Lifestyle Checklist

Name: _____ Date: _____ PRE/ POST

Please assign a value between 0 and 4 for each symptom.

0= never or non-existent / 1=seldom / 2=occasionally / 3=frequently / 4=always

1	Blurred vision at near	
2	Double vision	
3	Headaches associated with near work	
4	Words run together when reading	
5	Burning, stinging, watery eyes	
6	Falling asleep when reading	
7	Vision worse at the end of the day	
8	Skipping or repeating lines when reading	
9	Dizziness or nausea associated with near work	
10	Head tilt or closing one eye when reading	
11	Difficulty copying from the chalkboard	
12	Avoidance of reading and near work	
13	Omitting small words when reading	
14	Writing uphill or downhill	
15	Mis-aligning digits in columns of numbers	
16	Reading comprehension declining over time	
17	Inconsistent/poor sports performance	
18	Holding reading material too close	
19	Short attention span	
20	Difficulty completing assignments in reasonable time	
21	Saying "I can't" before trying	
22	Avoiding sports and games	
23	Difficulty with hand tools-scissors, calculator, keys, etc.	
24	Inability to estimate distances accurately	
25	Tendency to knock things over on desk or table	
26	Difficulty with time management	
27	Difficulty with money concepts, making change	
28	Misplaces or loses papers, objects, belongings	
29	Car sickness/motion sickness	
30	Forgetful, poor memory	

TOTAL _____