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Quality of Life Questionnaire

Name: _____ **Date:** _____

	<i>Completed by: <u>Self</u> / <u>Other: (Mom, Dad, guardian, etc.)</u></i>	Never	Seldom	Occasionally	Frequently	Always
1	I have blurred vision when looking at near objects.	0	1	2	3	4
2	I have double vision. (Seeing two objects rather than one.)	0	1	2	3	4
3	I have headaches with near work.	0	1	2	3	4
4	Words run together when I read.	0	1	2	3	4
5	My eyes burn, itch and water.	0	1	2	3	4
6	I fall asleep when I read.	0	1	2	3	4
7	I see worse at the end of the day.	0	1	2	3	4
8	I skip or repeat lines when reading.	0	1	2	3	4
9	I feel dizzy or sick to my stomach with near work.	0	1	2	3	4
10	I tilt my head or cover an eye when reading.	0	1	2	3	4
11	I have difficulty copying from the chalkboard.	0	1	2	3	4
12	I avoid reading and near work.	0	1	2	3	4
13	I leave out small words when reading.	0	1	2	3	4
14	I write uphill or downhill (My handwriting tends to slant up or down).	0	1	2	3	4
15	Columns of numbers appear misaligned.	0	1	2	3	4
16	I don't understand what I read.	0	1	2	3	4
17	I am poor in sports.	0	1	2	3	4
18	I hold my reading very close.	0	1	2	3	4
19	I have trouble keeping attention on reading.	0	1	2	3	4
20	I have difficulty completing assignments on time.	0	1	2	3	4
21	I often say, "I can't" before trying.	0	1	2	3	4
22	I avoid sports and games.	0	1	2	3	4
23	I have poor hand/eye coordination	0	1	2	3	4
24	I do not judge distance accurately.	0	1	2	3	4
25	I am clumsy.	0	1	2	3	4
26	I do not use my time well.	0	1	2	3	4
27	I do not do well in figuring out change (money).	0	1	2	3	4
28	I lose papers and belongings.	0	1	2	3	4
29	I have trouble with car/motion sickness.	0	1	2	3	4
30	I am forgetful with a poor memory.	0	1	2	3	4
	Totals:					
	20-24 points = suspect 25 points or more=refer for care	Score:				