ESCONDIDO PREMIER EYECARE OPTOMETRIC CENTER
Tomorrow's Care for Your Eyes Today

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Patient Questionnaire for Vision Problem

Name: Date:

Do you suffer from any of the following signs or symptoms of potential vision problem?

Please Score as follows: (0 Never / 1 Seldom / 2 Occasionally / 3 Often / 4 Always)

Physical Signs Do you:	**Score**
Notice that distance objects look blurry?	
Have headaches while doing close work or when working on the computer?	
Blink excessively or rub your eyes?	
Hold books extremely close?	
Cover one eye by leaning on your hand?	
Fall asleep when reading?	
Notice that words run together when reading?	
Performance Problems Do you:	**Score**
Have trouble copying work from a distance?	
Avoid reading?	
Lose your place when reading?	
Skip or repeat words and lines?	
Have difficulty completing work in a reasonable time?	
Tend towards clumsiness?	
Reverse letters and numbers?	
Secondary Symptoms Do You:	**Score**
Have a short attention span?	
Have poor self-esteem and confidence at work?	
Do you procrastinate when work needs to be done?	
Have frustration and anxiety associated with work?	
Seem to perform below your potential?	
Total scores above 20 or any one question above "3" raises suspicion about a potential vision problem.	**Total**

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