BelleVue
SPECIALTY EYE CARE

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19 ITEM COVD-QOL CHECKLIST QUESTIONNAIRE

Name:_____ Today's Date: _____/_____/_____

Insert corresponding number in column that best represents the occurrence of each symptom.

		NEVER 0	SELDOM 1	OCCASIONAL 2	FREQUENTLY 3	ALWAYS 4
1. Headaches with near work	A					
2. Words run together reading	B					
3. Burn, itch, watery eyes	B					
4. Skips/repeats lines reading	OM					
5. Head tilt/close one eye when reading	B					
6. Difficulty copying from chalkboard	A					
7. Avoids near work/reading	A					
8. Omits small words when reading	OM					
9. Writes up/down hill	O					
10. Misaligns digits/columns of numbers	OM					
11. Reading comprehension down	P					
12. Holds reading too close	A					
13. Trouble keeping attention on reading	P					
14. Difficulty completing assignments on time	*					
15. Always says "I can't" before reading	P					
16. Clumsy, knocks things over	O					
17. Does not use his/her time well	P					
18. Loses belongings/things	P					
19. Forgetful/poor memory	P					

A=Accommodation; B=Binocularity; O=Orientation; OM=Ocularmotor; P=Perception; *=All

Tally up the numbers to get the total score. Any score of 20 or above is questionable of a visual deficit; a score of 25 or more is almost certainly a vision problem.

TOTAL = 0

Completed By: _____