College of Optometrists in Vision Development Quality of Life Checklist

Patient Name ______________________________

Completed by ______________________________

Check the column that best represents the frequency of each symptom then total your or your child's score.

	Never	Seldom	Occasional	Frequently	Always	Score
Headaches with near work	0	1	2	3	4	
Words run together reading	0	1	2	3	4	
Burning, itching, watery eyes	0	1	2	3	4	
Skips/repeats lines reading	0	1	2	3	4	
Head tilt/closes one eye when reading	0	1	2	3	4	
Difficulty copying from the chalkboard	0	1	2	3	4	
Avoids near work/reading	0	1	2	3	4	
Omits small words when reading	0	1	2	3	4	
Writes up/down hill	0	1	2	3	4	
Misaligns digits/columns of numbers	0	1	2	3	4	
Reading comprehension low	0	1	2	3	4	
Holds reading material too close	0	1	2	3	4	
Trouble keeping attention on reading	0	1	2	3	4	
Difficulty completing assignments on time	0	1	2	3	4	
Always say "I can't" before trying	0	1	2	3	4	
Clumsy, knocks things over	0	1	2	3	4	
Does not use his/her time well	0	1	2	3	4	
Loses belongings/things	0	1	2	3	4	
Forgetful/poor memory	0	1	2	3	4	

Total Score	