Gabrielle Family Vision Care
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Child COVD Quality of Life Questionnaire

30-Item COVD-QOL Checklist

Patient's Name: **DOB (M/D/Yr):**

Date Completed: **Completed By:**

Please note that if these questions are too difficult to answer regarding the patient (ie. patients 5 years and younger), please return the form to our front desk staff.

Please circle the corresponding number that best represents the occurrence of each symptom. *Please note that it is not uncommon for a family member to have different observations than the patient and that this is okay.

0: Never 1: Seldom 2: Occasionally 3: Frequently 4: Always

Patient's View		Family Member's View of the Patient
0 1 2 3 4	Blur when looking at near	0 1 2 3 4
0 1 2 3 4	Double vision	0 1 2 3 4
0 1 2 3 4	Headaches with near work	0 1 2 3 4
0 1 2 3 4	Words run together when reading	0 1 2 3 4
0 1 2 3 4	Burning, itchy, watery eyes	0 1 2 3 4
0 1 2 3 4	Falls asleep when reading	0 1 2 3 4
0 1 2 3 4	Sees worse at the end of the day	0 1 2 3 4
0 1 2 3 4	Skips/repeats lines when reading	0 1 2 3 4
0 1 2 3 4	Dizzy/nausea with near work	0 1 2 3 4
0 1 2 3 4	Head tilt/close one eye when reading	0 1 2 3 4
0 1 2 3 4	Difficulty copying from board/overhead	0 1 2 3 4
0 1 2 3 4	Avoids near work/reading	0 1 2 3 4
0 1 2 3 4	Omits small words when reading	0 1 2 3 4
0 1 2 3 4	Writes up/downhill	0 1 2 3 4
0 1 2 3 4	Misaligns digits/columns of numbers	0 1 2 3 4
0 1 2 3 4	Reading comprehension down	0 1 2 3 4
0 1 2 3 4	Poor/inconsistent in sports	0 1 2 3 4
0 1 2 3 4	Holds reading too close	0 1 2 3 4
0 1 2 3 4	Trouble keeping attention on reading	0 1 2 3 4
0 1 2 3 4	Difficulty completing assignments on time	0 1 2 3 4
0 1 2 3 4	Always says "I can't" before trying	0 1 2 3 4
0 1 2 3 4	Avoids sports/games	0 1 2 3 4
0 1 2 3 4	Poor hand/eye (poor handwriting)	0 1 2 3 4
0 1 2 3 4	Does not judge distance accurately	0 1 2 3 4
0 1 2 3 4	Clumsy, knocks things over	0 1 2 3 4
0 1 2 3 4	Does not use his/her time well	0 1 2 3 4
0 1 2 3 4	Does not make change well	0 1 2 3 4
0 1 2 3 4	Loses belongings/things	0 1 2 3 4
0 1 2 3 4	Car/motion sickness	0 1 2 3 4
0 1 2 3 4	Forgetful/poor memory	0 1 2 3 4
total=	**Add numbers together for each column to find totals**	total=

Please contact Gabrielle Family Vision Care via email or phone to schedule an appointment.

A score of greater than 20 in either column is of concern and suggests that further evaluation is needed.