Gabrielle Family Vision Care
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Near Symptom Survey

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

Date Completed: **Completed By:**

Instructions: Please answer the following questions about how your eyes feel when reading or doing close work.

Please note 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.

		Never	Infrequently (not very often)	Sometimes	Fairly often	Always
1.	Do your eyes feel **tired** when reading or doing close work?					
2.	Do your eyes feel **uncomfortable** when reading or doing close work?					
3.	Do you have **headaches** when reading or doing close work?					
4.	Do you feel **sleepy** when reading or doing close work?					
5.	Do you **lose concentration** when reading or doing close work?					
6.	Do you have **trouble remembering** what you have read?					
7.	Do you have **double vision** when reading or doing close work?					
8.	Do you see the **words move, jump, swim** or appear to float on the page when reading or doing close work?					
9.	Do you feel like you read **slowly**?					
10.	Do your eyes ever **hurt** when reading or doing close work?					
11.	Do your eyes ever feel **sore** when reading or doing close work?					
12.	Do you feel a **"pulling"** feeling around your eyes when reading or doing close work?					
13.	Do you notice the words **blurring or coming in and out of focus** when reading or doing close work?					
14.	Do you **lose your place** while reading or doing close work?					
15.	Do you have to **re-read** the same line of words when reading?					
		___x 0	___x 1	___x 2	___x 3	___x 4

TOTAL SCORE_____