

ADULT VISUAL EFFICIENCY CHECKLIST

Patient Name _____ Age _____ Date _____

Address _____ City _____ State _____ Zip _____

Please estimate how often you exhibit the symptoms on this list. Give a score of 1 if you never have the symptom. Give a score of 6 if the symptom occurs all the time.

Symptom

Please Circle

Never-----Always

Headaches 1 2 3 4 5 6

Tired or sore eyes 1 2 3 4 5 6

Words “running together” while reading 1 2 3 4 5 6

Loss of place while reading 1 2 3 4 5 6

Distant objects blurred when first looking
up from reading or computer 1 2 3 4 5 6

Loss of comprehension as reading continues 1 2 3 4 5 6

How long can you comfortably read and still easily understand what you are reading?

- a) less than 15 minutes
- b) 15 to 30 minutes
- c) 30 minutes to 1 hour
- d) greater than 1 hour

How many hours per day do you spend on a computer? Is this continuous time?

Does your vision interfere with other activities you need to do or would like to do?

Do you have a child who is struggling in school?