# ADULT'S VISION CHECKLIST

Patient's Name______________________Age ________Date __________

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<br>Never ----------------------Always | | | | | |
|---|---|---|---|---|---|---|
| 1. Headaches. | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. Tired or sore eyes. | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. Words running together while reading. | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. Loss of place while reading. | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. Distance objects blurred when first | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. Loss of comprehension as reading | 1 | 2 | 3 | 4 | 5 | 6 |

What would you like to improve about your vision?

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