



Vision Symptom Questionnaire

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Scoring Never = 0
 Seldom = 1
 Sometimes = 2
 Frequently = 3
 Always = 4

						Score
Headaches with near work	0	1	2	3	4	
Words run together reading	0	1	2	3	4	
Burn, itch, watery eyes	0	1	2	3	4	
Skips/repeats lines reading	0	1	2	3	4	
Head tilt/close one eye reading	0	1	2	3	4	
Difficulty copying from board	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 numbers	0	1	2	3	4	
Reading comprehension down	0	1	2	3	4	
Holds reading too close	0	1	2	3	4	
Trouble keeping attention reading	0	1	2	3	4	
Difficulty completing assignments on time	0	1	2	3	4	
Says "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 = _____

* A score of 20 or above indicates a likely visual problem and referral

Referral by _____ School _____