SCREENING QUESTIONNAIRE
Binocular Vision Dysfunction / Vertical and Horizontal Heterophoria
For Ages 14 and up

Name: _____

Date: _____

Phone Number: _____

Email: _____

SECTION 1

Directions: For each of the following questions, please indicate how often this occurs. If you wear glasses or contact lenses, please answer the questions assuming that you are wearing them.

- (A) Always = every day
- (F) Frequently = at least once per week
- (O) Occasionally = less than once per week
- (N) Never = never

		A	F	O	N
1	Do you experience headaches, "pressure" in your head, and/or facial pain?				
2	Do you have pain in your eyes with eye movement?				
3	Do you have neck or shoulder discomfort?				
4	Do you have dizziness, lightheadedness, and/or a spacey feeling?				
5	Do you experience dizziness, lightheadedness, spaciness, or nausea while performing near activities (using a computer/mobile device, reading, etc.)?				
6	Do you experience dizziness, lightheadedness, spaciness, or nausea while performing far-distance activities (driving, watching television or movies, reading PowerPoint slides at work/school, etc.)				
7	Do you experience dizziness, lightheadedness, spaciness, or nausea when bending down and standing back up, or when getting up quickly from a seated position?				
8	Do you feel unsteady or drift to one side while walking?				
9	Do you feel anxious or overwhelmed while shopping in a large store (Costco, Target, Walmart, etc.)?				

		A	F	O	N
10	Do you feel anxious or overwhelmed moving through crowds of people?				
11	Does riding in a car make you feel dizzy or uncomfortable (nausea, headaches)?				
12	Do you experience anxiety or nervousness because of your dizziness?				
13	Do you ever find yourself with your head tilted to one side? Or, have other people noticed that you sometimes tilt your head?				
14	Do you experience poor depth perception or have difficulty estimating distances accurately?				
15	Do you experience double / overlapping / shadowed vision at far distances?				
16	Do you experience double / overlapping / shadowed vision at near distances?				
17	Do you experience glare or are you super-sensitive to light?				
18	Do you close or cover one eye with near or far tasks?				
19	Do you skip lines or lose your place when you are reading? Do you use your finger, ruler, or other guides to maintain your position on the page?				
20	Do you tire easily with close-up tasks (using a computer/mobile device, reading, etc.)?				
21	Do you experience blurred vision with far-distance activities (driving, watching television or movies, reading PowerPoint slides at work/school, etc.)?				
22	Do you experience blurred vision with close-up activities (using a computer/mobile device, reading, etc.)?				
23	Do you blink to “clear up” distant objects after doing close-up activities (using a computer/mobile device, reading, etc.)?				
24	Do you experience words running together while reading?				
25	Do you experience difficulty with reading or reading comprehension? Does your reading comprehension start off well, but deteriorate over time?				
	TOTALS				

SECTION 2

1 Have you ever been diagnosed with a concussion? _____

If yes, how many concussions have you had? _____

2 Have you ever been diagnosed with a lazy eye? _____

3 Have you ever been diagnosed with a reading disability? _____

4 Have you ever had an eye operation (LASIK, cataract, retina)? _____

5 Have you ever had an eyelid operation? _____

6 Have you ever been diagnosed with a traumatic brain injury? _____

SECTION 3

On an average day, how much are you bothered by symptoms listed here?
Rate each symptom from 0 – 10, with 0 = None of that symptom, and 10 = Worst.

1. Dizziness: _____
2. Nausea: _____
3. Anxiety: _____
4. Headache: _____
5. Neckache: _____
6. Unsteady when walking: _____
7. Sensitivity to light: _____
8. Reading difficulty: _____

Please record any additional symptoms you may be experiencing or specific concerns that you have about your eyes / vision. (You can use additional pages if necessary.)

_____

_____

_____

_____