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STUDENT QUALITY OF LIFE VISION QUESTIONNAIRE (QUOL)

Patient's Name________________________________ Date__________ Pre / Re-Eval / Post

Filled out by: (1)___________________________(2)___________________________

Please assign a value between 0 and 4 for each symptom.
0= never or non-existent, 1=seldom, 2=sometimes, 3=frequently, 4=always

Please add a cross if you have seen a recent improvement in this area (and two crosses for a large improvement).

		(1)	(2)
1.	Blurred vision at near		
2.	Double vision		
3.	Sees worse at the end of the day		
4.	Burning, itchy, watery eyes		
5.	Headaches or eye ache with near work		
6.	Falls asleep reading		
7.	Words run together when reading		
8.	Skips lines or repeats lines when reading		
9.	Dizziness or light headedness or sick feeling with near work		
10.	Head tilt or closing one eye when reading		
11.	Holds reading too close		
12.	Omits small words when reading		
13.	Trouble keeping attention on reading		
14.	Avoidance of reading or near work		
15.	Reading comprehension weakness		
16.	Misaligns digits in columns of numbers		
17.	Writes uphill or downhill or drifts off margin		
18.	Difficulty completing assignments on time		
19.	Says "I can't " before trying		
20.	Difficulty copying from the board		
21.	Poor eye-hand (poor handwriting)		
22.	Avoids sports/games		
23.	Inconsistent or poor performance in sports		
24.	Does not judge distances/speed accurately		
25.	Clumsy, knocks things over		
26.	Does not use time well		
27.	Does not accept changes easily		
28.	Loses papers, belongings		
29.	Car sickness / motion sickness		
30.	Forgetful or poor memory		
TOTAL			

Please add any further comments to the reverse of this form.
Thank you for your time. The results of these surveys help us design our care programmes.