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Head Injury Vision Symptom Questionnaire

Patient Name:_____ Date: _____

Instructions: Please circle the item that best matches your symptoms today. Please rate each symptom. How often does each occur? (circle a number)

	Never	Seldom	Occasional	Frequently	Always
Eyesight Clarity					
Distance vision blurred (Not clear with or without lenses)	0	1	2	3	4
Near vision blurred (Not clear with or without lenses)	0	1	2	3	4
Clarity of vision changes or fluctuates during the day	0	1	2	3	4
Poor night vision / can't see well to drive at night	0	1	2	3	4
Visual Comfort					
Eye discomfort / sore eyes / eyestrain	0	1	2	3	4
Headaches or dizziness after using eyes	0	1	2	3	4
Eye fatigue (Very tired after using eyes all day)	0	1	2	3	4
Feel "pulling" around the eyes	0	1	2	3	4
Doubling					
Double vision (Especially when tired)	0	1	2	3	4
Have to close or cover one eye to see clearly	0	1	2	3	4
Print moves in and out of focus when reading	0	1	2	3	4
Dry Eyes					
Eyes feel "dry" and sting	0	1	2	3	4
"Stare" into space without blinking	0	1	2	3	4
Have to rub the eyes a lot	0	1	2	3	4

Patient Name:_____ Date: _____

Instructions: Please circle the item that best matches your symptoms today. Please rate each symptom. How often does each occur? (circle a number)

	Never	Seldom	Occasional	Frequently	Always
Light Sensitivity					
Normal indoor lighting is uncomfortable (Too much glare)	0	1	2	3	4
Outdoor light too bright (Have to use sunglasses)	0	1	2	3	4
Indoors fluorescent lighting is bothersome or annoying	0	1	2	3	4
Depth Perception					
Clumsiness / misjudge where objects really are	0	1	2	3	4
Lack of confidence walking / missing steps / stumbling	0	1	2	3	4
Poor handwriting (spacing, size, legibility)	0	1	2	3	4
Peripheral Vision					
Side vision distorted / objects move or change position	0	1	2	3	4
What looks straight ahead isn't always straight ahead	0	1	2	3	4
Avoid crowds / can't tolerate "visually-busy" places	0	1	2	3	4
Reading					
Short attention span/easily distracted when reading	0	1	2	3	4
Difficulty / slowness with reading and writing	0	1	2	3	4
Poor reading comprehension/can't remember what was read	0	1	2	3	4
Confusion of words / skip words during reading	0	1	2	3	4
Lose place/use finger not to lose place when reading	0	1	2	3	4

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Sound Sensitivity Questionnaire

Name: _____ Date: _____

Instructions: Mark the box corresponding to the answer which best applies to you.	No	Yes, a little	Yes, quite a bit	Yes, a lot
1. Do you ever use earplugs or earmuffs to reduce your noise perception (Do not consider the use of hearing protection during abnormally high noise exposure situations)?				
2. Do you find it harder to ignore sounds around you in everyday situations?				
3. Do you have trouble reading in a noisy or loud environment?				
4. Do you have trouble concentrating in noisy surroundings?				
5. Do you have difficulty listening to conversations in noisy places?				
6. Has anyone you know ever told you that you tolerate noise or certain kinds of sound badly?				
7. Are you particularly sensitive to or bothered by street noise?				
8. Do you find the noise unpleasant in certain social situations (e.g. night clubs, pubs or bars, concerts, firework displays, cocktail receptions)?				
9. When someone suggests doing something (going out, to the cinema, to a concert, etc.), do you immediately think about the noise you are going to have to put up with?				
10. Do you ever turn down an invitation or not go out because of the noise you would have to face?				
11. Do noises or particular sounds bother you more in a quiet place than in a slightly noisy room?				
12. Do stress and tiredness reduce your ability to concentrate in noise?				
13. Are you less able to concentrate in noise towards the end of the day?				
14. Do noise and certain sounds cause you stress and irritation?				

ITHACA EYECARE OPTOMETRY

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Name _____ **Date**_____

MAV (Migraine Associated Vertigo) Symptom Trigger Checklist

INSTRUCTIONS:
Please select all items on the list that bring on or trigger symptoms. For each item selected, check off every symptom that is triggered. List any additional symptoms in the other symptoms column.

Triggers	Headaches	Dizziness	Ear Ringing	Ear fullness	Facial fullness	Other symptoms
Caffeine						
Chocolate						
MSG (monosodium glutamate)						
Aged, canned or cured meats						
Aged Cheese						
Yogurt						
Nuts						
Red Wines						
Citrus Fruits						
Bananas						
Onions						
Fresh bread (<24hrs old)						
Aspartame						
Soy Products						
Legumes (peanut butter)						
Barometric pressure changes						
Strong Perfume or fragrances						
Bright Lights						
Loud Sounds						
Other:						