Pre-Assessment Questionnaire - Adult

DATE	
NAME & SURNAME	
REFERRED BY	
OCCUPATION	

Please tick ✔ any symptoms and statements that apply to you.		
OCULAR HISTORY		
Currently wearing glasses or contact lenses		
Previous visual therapy, eye patching or surgery		
Family history of eye disease		
Currently using eye drops		
SYMPTOMS		
Blurry vision in the DISTANCE (even with spectacles)		
Blurry vision at NEAR (even with spectacles)		
Double vision		
Fatigue with reading & computer work		
Regular headaches		
Light & glare sensitivity		
Balance problems, dizziness, vertigo		
Discomfort scrolling on digital device or watching TV		
Itchy, gritty, dry or watery eyes.		
Frequently red eyes		

VISUAL DEMANDS	Rare	1-2 hours/day	3-4 hours/day	+4 hours/day
Near tasks: Reading & digital devices eg. phone				
Computer work				
Intermediate-distance tasks: office, meetings, lectures				
Driving				
Night Driving				
Fine detail tasks, hobbies or sports *(please specify)*				
Specific work / lifestyle vision requirements				