SUNY COLLEGE OF OPTOMETRY
UNIVERSITY EYE CENTER

Convergence Insufficiency Symptom Survey

NAME _____ **DATE** _____/_____/_____

MRN _____ **DOB** _____/_____/_____ **AGE** _____

Instructions

For PATIENT self-completing the survey: Please answer the following questions.

For PARENT or CLINICIAN assisting a patient: Read the questions exactly as written. If the patient responds "yes," ask about the frequency of the symptom. Do not give examples.

		Never	Infrequently (not very often)	Sometimes	Fairly often	Always
1.	Do your eyes feel tired when reading or doing close work?					
2.	Do your eyes feel uncomfortable when reading or doing close work?					
3.	Do you have headaches when reading or doing close work?					
4.	Do you feel sleepy when reading or doing close work?					
5.	Do you lose concentration when reading or doing close work?					
6.	Do you have trouble remembering what you have read?					
7.	Do you have double vision when reading or doing close work?					
8.	Do you see the words move, jump, swim or appear to float on the page when reading or doing close work?					
9.	Do you feel like you read slowly?					
10.	Do your eyes ever hurt when reading or doing close work?					
11.	Do your eyes ever feel sore when reading or doing close work?					
12.	Do you feel a "pulling" feeling around your eyes when reading or doing close work?					
13.	Do you notice the words blurring or coming in and out of focus when reading or doing close work?					
14.	Do you lose your place while reading or doing close work?					
15.	Do you have to re-read the same line of words when reading?					
		__ x 0	__ x 1	__ x 2	__ x 3	__ x 4

Total Score: _____