INSIGHT
FAMILY EYE CARE

Insight Family Eye Care
Adult Questionnaire
(18 and over)

Patient Name:_________________________________Age:______Date:_____________

Please place a number for the appropriate occurrence of behavior.

Behavior:	1 (Never)	2 (Seldom)	3 (Occasionally)	4 (Frequently)	5 (All the time)
1. Do you have sore/tired/watery/irritated eyes?					
2. Do you get frequent headaches?					
3. Do you ever lose your place in the material you are reading?					
4. Do you fully comprehend what you are reading?					

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