INSIGHT
FAMILY EYE CARE

Insight Family Eye Care
Questionnaire for Ages 12-17

Patient Name:_____ **Age:**_____
Grade:_____ **Date:**_____

Please place a number in the column that best describes how often these behaviors occur. 1 being never and 5 being all the time.

Do you?	1 (Never)	2 (Seldom)	3 (Occasionally)	4 (Frequently)	5 (All the time)
1. Do your eyes feel tired/uncomfortable when looking close or far away?					
3. Do you feel like you read slowly/lose place when reading?					
4. Do you have to re-read the same line over or have a difficult time understanding what you are reading?					
5. Do you feel a "pulling" feeling when reading up close or far away?					
6. Do your words move around or get blurry when you are reading? Do you ever see double?					
7. Do you have a hard time staying focused or paying attention in school?					
8. Do you get frequent headaches during or after reading/writing?					
9. Does it take you a long time to complete homework or classwork?					
10. Do you have trouble copying from the board?					
11. Do you have a difficult time with sports?					

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