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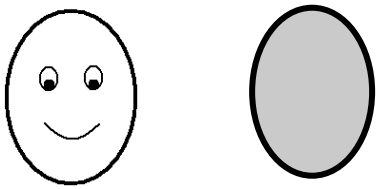
Binocular Vision Dysfunction Questionnaire (BVDQ)

Name: _____ **Email:**_____ **Date:** _____

Best phone number:_____ **Back-up phone number:**_____

Directions: For each of the following questions, please check the answer that best describes your situation. If you wear glasses or contact lenses, answer the questions assuming that you are wearing them. Always = Everyday Frequently = At least 1 time / week Occasionally = Less than 1 time / week Never = Never	✓ALWAYS	✓FREQUENTLY	✓OCCASIONALLY	✓NEVER
1. Do you have headaches and / or facial pain?				
Draw in location of discomfort **(Scale 1-10: 1=extremely mild, 10=extremely severe)**  **FACE** **BACK OF HEAD**				
2. Do you have pain in your eyes with eye movement?				
3. Do you experience neck or shoulder discomfort?				
4. Do you have dizziness and / or lightheadedness?				
5. Do you experience dizziness, light-headedness, or nausea while performing close-up activities (i.e. - computer work, reading, writing)?				
6. Do you experience dizziness, light-headedness, or nausea while performing far-distance activities (i.e. - driving, television, movies)?				
7. Do you experience dizziness, light-headedness, or nausea when bending down and standing back up, or when getting up quickly from a seated position?				
8. Do you feel unsteady with walking, or drift to one side while walking?				
9. Do you feel overwhelmed or anxious while walking in a large department store (i.e. – Target, Costco, Malls)?				
10. Do you feel overwhelmed or anxious when in a crowd?				
11. Does riding in a car make you feel dizzy or uncomfortable?				
12. Do you experience anxiety or nervousness because of your dizziness?				

	✓ALWAYS	✓FREQUENTLY	✓OCCASIONALLY	✓NEVER
13. Do you ever find yourself with your head tilted to one side?				
14. Do you experience poor depth perception or have difficulty estimating distances accurately?				
15. Do you experience double / overlapping / shadowed vision at far distances?				
16. Do you experience double / overlapping / shadowed vision at near distances?				
17. Do you experience glare or have sensitivity to bright lights?				
18. Do you close or cover one eye with near or far tasks?				
19. Do you skip lines or lose your place while reading (do you use your finger or a ruler or other guides to maintain your position on the page)?				
20. Do you tire easily with close-up tasks (computer work, reading, writing)?				
21. Do you experience blurred vision with far-distance activities (i.e. - driving, television, movies, chalkboard at school)?				
22. Do you experience blurred vision with close-up activities (i.e. - computer work, reading, writing)?				
23. Do you blink to "clear up" distant objects after working at a desk or working with close-up activities (i.e. - computer work, reading, writing)?				
24. Do you experience words running together with reading?				
25. Do you experience difficulty with reading or reading comprehension?				

Have you ever been diagnosed with any of the following:

Traumatic brain injury or concussion? ☐Y ☐N Lazy eye? ☐Y ☐N Reading disability? ☐Y ☐N

Have you ever had an eye operation? ☐ YES ☐ NO History of ear infections? ☐Y ☐N

On an average day, how much are you bothered by the 8 symptoms listed below? (Rate each symptom from 0 to 10, where 10 is the worst it could be, and where 0 means you have none of that symptom)

Dizziness = / 10
Nausea = / 10
Anxiety = / 10
Headache = / 10
Neckache = / 10
Unsteady with walking = / 10
Sensitivity to light = / 10
Reading difficulty = / 10

Please record any additional symptoms you may be experiencing or specific concerns that you have about your eyes / vision: