SCREENING QUESTIONNAIRE

For Ages 14 & Older

Binocular Vision Dysfunction Questionnaire (BVDQ™)

Name _____ Date _____

Phone Number _____ Email _____

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 = every day
Frequently = at least once per week
Occasionally = less than once per week
Never = never

		ALWAYS	FREQUENTLY	OCCASIONALLY	NEVER
1	Do you have headaches and/or facial pain?				
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 light headedness?				
5	Do you experience dizziness, light headedness, or nausea while performing close-up activities (computer work, reading, writing, etc.)?				
6	Do you experience dizziness, light headedness or nausea while performing far-distance activities (driving, television, movies, etc.)?				
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 or drift to one side while walking?				
9	Do you feel overwhelmed or anxious while walking in a large department store (Target, Wal-Mart, Costco, etc.)?				
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?				
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 when you are reading? Do you use your finger, 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 (driving, television, movies, chalkboard at school, etc.)?				
22	Do you experience blurred vision with close-up activities (computer work, reading, writing, etc.)?				
23	Do you blink to 'clear up' distant objects after working at a desk or working with close-up activities (computer work, reading, writing, etc.)?				
24	Do you experience words running together while reading?				
25	Do you experience difficulty with reading or reading comprehension?				
	TOTALS				

	YES	NO
Have you ever been diagnosed with a traumatic brain injury (TBI)?		
Have you ever been diagnosed with a concussion?		
Have you ever been diagnosed with a lazy eye?		
Have you ever been diagnosed with a reading disability?		
Have you ever had an eye operation?		

On an average day, how much are you bothered by symptoms listed here? Rate each symptom from 0-10 0 = None of that symptom 10 = Worst		None Worst		None Worst
	Dizziness	0 1 2 3 4 5 6 7 8 9 10	Neckache	0 1 2 3 4 5 6 7 8 9 10
	Nausea	0 1 2 3 4 5 6 7 8 9 10	Unsteady when walking	0 1 2 3 4 5 6 7 8 9 10
	Anxiety	0 1 2 3 4 5 6 7 8 9 10	Sensitivity to light	0 1 2 3 4 5 6 7 8 9 10
	Headache	0 1 2 3 4 5 6 7 8 9 10	Reading difficulty	0 1 2 3 4 5 6 7 8 9 10
			Sound sensitivity	0 1 2 3 4 5 6 7 8 9 10

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

_____

_____

_____

This questionnaire is designed to identify individuals whose symptoms (ex. headache, dizziness, anxiety, etc.) may be due to vision misalignment.

How to score this questionnaire:

For questions 1 - 25, scoring is as follows (see below). Add the scores for questions 1 - 25 to get a TOTAL score.

Always = _____ x 3 Frequently = _____ x 2 Occasionally = _____ x 1 Never = _____ x 0 **TOTAL** _____

Is your TOTAL score 15 or greater? Yes ☐ No ☐ ***If you checked "Yes", consider an examination by a NeuroVisual Specialist.***

On an average day, are you bothered by the following symptoms listed here?
Note your response by checking Yes or No for each.

	Yes	No
Do you have a fast heart rate / palpitations upon standing?	☐	☐
Do you have an intolerance to heat?	☐	☐
Does standing make your dizziness symptoms worse?	☐	☐
If you lie down, is your dizziness reduced?	☐	☐
Do you experience dizziness or notice an increase in dizziness when speaking loudly or in response to loud noises?	☐	☐
Do people mention to you that your speaking voice is soft even though it seems loud to you?	☐	☐
When you cough or sneeze do you feel like things are moving or does it make you dizzy?	☐	☐
Have you ever had the feeling that fluid was leaking out of one of your ears, yet there wasn't any fluid there?	☐	☐
Are you made uncomfortable by sounds that seem loud to you but not to your friend/ family?	☐	☐
Is your dizziness worse with head movement, particularly when rolling over in bed?	☐	☐

This questionnaire is designed to screen for those who may have difficulty with vision alignment. The information obtained herein is considered a preliminary result only and does not diagnose or constitute confirmation of any vision problems. It is not a substitute for a NeuroVisual examination. Since vision changes can occur without visible indications, most eye care professionals and medical authorities recommend a vision exam annually