

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:

	<u>Yes</u>	<u>No</u>	<u>Prior to Injury?</u>
Eyes ache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes pull or tug	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty moving or turning eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain with movement of eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes twitch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in or around eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brightness is bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motion sickness / car sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty changing focus far to near	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<u>Yes</u>	<u>No</u>	<u>Prior to Injury?</u>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One eye turns in, out, up or down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Movement of objects in the environment is bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluorescent light is bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patterned wallpaper or carpets are bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head moves when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lose place often when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Words jump or move around when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short attention span for reading or writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skip words frequently when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discomfort when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of interest/concentration when doing close work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orient writing/drawing poorly on page	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squinting, covering or closing one eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head tilts during desk work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hold books too close	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoid reading or writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>