Brain Injury Vision Symptom Survey
BIVSS

Name:_____
MR:_____Date:_____

0 = Never 1 = Seldom 2 = Occasionally 3 = Frequently 4 = Always

EYESIGHT CLARITY					
Distance vision blurred and not clear - even with lenses	0	1	2	3	4
Near vision blurred and not clear - even with lenses	0	1	2	3	4

Please rate each behaviour

How often does each behaviour occur? (circle a number)

Clarity of vision changes or fluctuates during the day	0	1	2	3	4
Poor night vision / can't see well to drive at night	0	1	2	3	4

VISUAL COMFORT					
Eye discomfort / sore eyes / eystrain	0	1	2	3	4
Headaches or dizziness after using eyes	0	1	2	3	4
Eye fatigue / very tired after using eyes all day	0	1	2	3	4
Feel "pulling" around the eyes	0	1	2	3	4

DOUBLING					
Double vision - especially when tired	0	1	2	3	4
Have to close or cover one eye to see clearly	0	1	2	3	4
Print moves in and out of focus when reading	0	1	2	3	4

LIGHT SENSITIVITY					
Normal indoor lighting is uncomfortable - too much glare	0	1	2	3	4
Outdoor light too bright - have to use sunglasses	0	1	2	3	4
Indoor fluorescent lighting is bothersome or annoying	0	1	2	3	4

DRY EYES					
Eyes feel "dry" and sting	0	1	2	3	4
"Stare" into space without blinking	0	1	2	3	4
Have to rub eyes a lot	0	1	2	3	4

DEPTH PERCEPTION					
Clumsiness / misjudge where objects really are	0	1	2	3	4
Lack of confidence walking / missing steps / stumbling	0	1	2	3	4
Poor handwriting (spacing, size, legibility)	0	1	2	3	4

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PERIPHERAL VISION					
Side vision distorted / objects move or change position	0	1	2	3	4
What looks straight ahead - isn't always straight ahead	0	1	2	3	4
Avoid crowds / can't tolerate "visually-busy" places	0	1	2	3	4

READING					
Short attention span / easily distracted when reading	0	1	2	3	4
Difficulty / slowness with reading and writing	0	1	2	3	4
Poor reading comprehension / can't remember what was read	0	1	2	3	4
Confusion of words / skip words during reading	0	1	2	3	4
Lose place / have to use finger not to lost place when reading	0	1	2	3	4