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# Pediatric Binocular Vision Dysfunction Progress Assessment Questionnaire (BVDQ)

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

**Directions:** Children - answer these questions together with your Parents. For every question, check the answer that best describes your situation. If you wear glasses or contact lenses, answer the questions assuming that you are wearing them. Please answer every question.

**Never** = Never
**Occasionally** = Less than 1 time / week
**Frequently** = At least 1 time / week
**Always** = Everyday

| | ✓NEVER | ✓OCCASIONALLY | ✓FREQUENTLY | ✓ALWAYS |
|---|---|---|---|---|
| **1. Do you have headaches or face pain?** | | | | |
| **2. Do your eyes hurt and/or does it hurt to move your eyes?** | | | | |
| **3. Do you have neck pain or a stiff neck or upper back pain?** | | | | |
| **4. Do you have stomach aches or nausea?** | | | | |
| **5. Do you get car sickness or motion sickness?** | | | | |
| **6. Did you get sick in the car seat when you were a small child?** | | | | |
| **7. Do you get sick to your stomach or nauseous on swings or circular rides?** | | | | |
| **8. Does riding in the car give you headaches or stomach aches?** | | | | |
| **9. Do you have trouble reading in the car?** | | | | |
| **10. Do you feel clumsy or klutzy or uncoordinated?** | | | | |
| **11. When you are walking, do you bump into people or furniture or door frames?** | | | | |
| **12. Do you feel funny or dizzy when you bend over and stand back up quickly?** | | | | |
| **13. Are you anxious or nervous?** | | | | |
| **14. In grocery stores or malls, do you stay close (cling) to your Mom or Dad? (Do you feel uncomfortable in grocery stores or malls?)** | | | | |
| **15. Do you tend to play alone or with just a few other kids? (Do you tend to play apart from the main group of kids?)** | | | | |
| **16. Is reading hard for you or are you a slow reader?** | | | | |
| **17. Do you have to read the same thing a couple of times to really understand it?** | | | | |

| | ✓NEVER | ✓OCCASIONALLY | ✓FREQUENTLY | ✓ALWAYS |
|---|---|---|---|---|
| **18. Do you use your finger or a ruler or a piece of paper to help you keep your place when you are reading?** | | | | |
| **19. Do you skip lines or lose your place when you are reading?** | | | | |
| **20. When you read, does it look like the letters are moving OR does it seem like words are bumping into each other?** | | | | |
| **21. Do bright lights hurt your eyes?** | | | | |
| **22. Do you close or cover one eye to make it easier to see?** | | | | |
| **23. Do you have trouble catching baseballs or footballs or Frisbees?** | | | | |
| **24. Do you ever see two of everything (double vision)?** | | | | |
| **25. Is it hard for you to watch 3-D movies?** | | | | |
| **26. When reading or working on the computer, do your eyes feel tired or does your vision get blurry?** | | | | |
| **27. When looking at the blackboard at school, do your eyes feel tired or does your vision get blurry?** | | | | |

| | |
|---|---|
| **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)**<br>**1. Dizziness = / 10**<br>**2. Nausea = / 10**<br>**3. Anxiety = / 10**<br>**4. Headache = / 10**<br>**5. Neckache = / 10**<br>**6. Unsteady with walking= / 10**<br>**7. Sensitivity to light = / 10**<br>**8. Reading difficulty = / 10** | **Compared to the way I felt before I came to City Optometry: If you are feeling better, by what percentage have you improved?**<br><br>**_____% improved**<br><br>**Please record any additional symptoms you may be experiencing or specific concerns that you have about your eyes / vision:** |