Vision Quality of Life with Time Survey (VisQuaL-T)

Study ID: _____ DOB: ___/___/_____ Date: ___/___/_____

Subject Instructions: We are interested in finding out if you have symptoms when you do certain activities, and if you develop symptoms, how long it takes before they begin. Symptoms include headache, dizziness, eye strain, double vision, floating words, blurry vision, inability to pay attention, easily distracted, or sleepy/drowsy. If you do not perform a specific activity and it is not applicable to you, select N/A. If you never experience any of the symptom listed above for the specific activity, select 60+ min.

Note: If you select more than four N/A's, fill out one Optional Additional Activity for each N/A's above four. For example, if you selected 6 N/A's, fill out two of the Optional Additional Activities. In the Optional Activities, fill out an activity you perform regularly that is more applicable to you.

Activities Important to You	0 – 15 min	15 – 30 min	30 – 45 min	60+ min	N/A
Read for pleasure?	0	1	2	3	N/A
Study for a test / examination?	0	1	2	3	N/A
Complete homework?	0	1	2	3	N/A
Complete work in an office setting? (i.e. reading / writing / typing reports)	0	1	2	3	N/A
Be in crowded locations? (i.e. malls, train station, airports, meetings, busy walkways, etc.)	0	1	2	3	N/A
Tolerate habitual lighting in a classroom or workplace?	0	1	2	3	N/A
Use a smartphone / tablet?	0	1	2	3	N/A
Play a computer / console video game?	0	1	2	3	N/A
Use a computer or laptop for general purposes? (i.e. email, Facebook, etc.)	0	1	2	3	N/A
Watch a show / movie on a screen larger than 9"? (iPad Pro or larger)	0	1	2	3	N/A
Additional Activity 1: _____	0	1	2	3	N/A
Additional Activity 2:_____ _____	0	1	2	3	N/A
Additional Activity 3:_____ _____	0	1	2	3	N/A
	__ x 0	__ x 1	__ x 2	__ x 3	N/A

Total: _____

Y-Score (Total / number of questions answered): _____