VISUAL SYMPTOM ASSESSMENT QUESTIONNAIRE (VSAQ-ALK)

We would like to ask some questions about problems you may be experiencing with your eyesight. These problems are called visual disturbances and may include but are not limited to the appearance of the following: overlapping shadows or after images; shimmering, flashing or trailing lights; streamers, strings, or floaters in your peripheral vision; as well as hazy or blurry vision.

Please select the response that best applies to your experience of visual disturbances in the <u>past three weeks</u>.

1) In the past three weeks, have you experienced any visual disturbances?

□ Yes If ***yes*** go to Question 2.
□ No If ***no***, thank you and please return the questionnaire.

2) In the past three weeks, how often did you experience a visual disturbance?

□ One day a week or less often
□ Two or three days a week
□ Four to six days a week
□ Seven days a week

3) In the past three weeks, when did you experience a visual disturbance? (Check <u>all</u> that apply)

□ Morning
□ Afternoon (from 12 PM -4 PM)
□ Evening

4) In the past three weeks, how long did each visual disturbance last on average? (Check only <u>one</u>)

□ 30 seconds or less
□ More than 30 seconds but not longer than one minute
□ More than one minute but not longer than five minutes
□ More than five minutes but not longer than ten minutes
□ More than ten minutes
□ Don't remember

5) In the past three weeks, how often did you experience a visual disturbance when adjusting to changes in lighting (e.g., coming indoors on a bright sunny day)?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

6) In the past three weeks, how much have you been bothered by. . . (Check <u>one</u> box on each line below):

	Did not experience	Not at all	A little	Moderately	Quite a bit	Extremely
a. Visual disturbances?	☐	☐	☐	☐	☐	☐
b. Appearance of overlapping shadows or after images?	☐	☐	☐	☐	☐	☐
c. Appearance of shimmering, flashing, or trailing lights?	☐	☐	☐	☐	☐	☐
d. Appearance of streamers, strings, or floaters?	☐	☐	☐	☐	☐	☐
e. Difficulty seeing at night?	☐	☐	☐	☐	☐	☐
f. Hazy or blurry vision?	☐	☐	☐	☐	☐	☐
g. Difficulty adapting to bright lights (e.g., going out on a bright day)?	☐	☐	☐	☐	☐	☐
h. Difficulty adapting to dim light (e.g., entering a darkened room)?	☐	☐	☐	☐	☐	☐

7) During the past three weeks, how much did visual disturbances affect your ability to do your regular daily activities?

By regular activities, we mean the usual activities you do, such as work around the house, shopping, child care, exercising, studying, etc. Think about times you were limited in the amount or kind of activities you could do and times you accomplished less than you would like. If visual disturbances affected your activities only a little, choose a low number. Choose a high number if visual disturbances affected your activities a great deal.

Consider only how much visual disturbances affected your ability to do your regular daily activities

Visual disturbances had no effect on my daily activities											Visual disturbances completely prevented me from doing my daily activities
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

CIRCLE A NUMBER