Vermont Laser Vision at Timber Lane
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PATIENT SYMPTOM QUESTIONNAIRE

Patient Name: _____ Date: _____

Patient Instructions: Please check the appropriate box to rate your symptoms, if any, that you may be experiencing for each of the following categories of potential eye and vision symptoms.

Symptom	Your Personal Experience				
Light Sensitivity	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Headaches	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Eye Pain Upon Awakening	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Eye Pain During the Day	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Redness	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Dry Eye	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Excessive Tearing	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Burning	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Gritty Feeling	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Glare	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Halos Around Lights	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Blurry Vision	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Double Vision	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Ghost Images	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Fluctuations of Vision	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Difficulty with Night Driving	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Variable Vision under:	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Bright Light/Sun	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Normal/Indoor Light	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Dim Light/After Dark	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe

For Office Use Only:	☐ Pre-op	☐ Post-op _____	Reviewed by:_____