

Near-work symptom survey (CISS)

PATIENT NAME _____

DATE OF BIRTH _____

DATE _____

Read each question aloud and check how often it happens **when reading or doing close work**, wearing their usual glasses. Do not explain or reword the questions. If a child doesn't understand a choice, read all five again. **For ages 9 and up**; for younger children, use the kit findings only.

Question	Never 0	Not very often 1	Some- times 2	Fairly often 3	Always 4
1 Do your eyes feel tired when reading or doing close work?	☐	☐	☐	☐	☐
2 Do your eyes feel uncomfortable when reading or doing close work?	☐	☐	☐	☐	☐
3 Do you have headaches when reading or doing close work?	☐	☐	☐	☐	☐
4 Do you feel sleepy when reading or doing close work?	☐	☐	☐	☐	☐
5 Do you lose concentration when reading or doing close work?	☐	☐	☐	☐	☐
6 Do you have trouble remembering what you have read?	☐	☐	☐	☐	☐
7 Do you have double vision when reading or doing close work?	☐	☐	☐	☐	☐
8 Do you see the words move, jump, swim or appear to float on the page when reading or doing close work?	☐	☐	☐	☐	☐
9 Do you feel like you read slowly?	☐	☐	☐	☐	☐
10 Do your eyes ever hurt when reading or doing close work?	☐	☐	☐	☐	☐
11 Do your eyes ever feel sore when reading or doing close work?	☐	☐	☐	☐	☐
12 Do you feel a "pulling" feeling around your eyes when reading or doing close work?	☐	☐	☐	☐	☐
13 Do you notice the words blurring or coming in and out of focus when reading or doing close work?	☐	☐	☐	☐	☐
14 Do you lose your place while reading or doing close work?	☐	☐	☐	☐	☐
15 Do you have to re-read the same line of words when reading?	☐	☐	☐	☐	☐
Number of checks in each column	—	×1	×2	×3	×4

Scoring

Multiply each column count by its value (×1 to ×4) and add them (0–60).
Refer when the total is 16 or more for children, or 21 or more for adults, along with any positive finding on the kit screen.

Total score

_____ / 60

Screening kit results

PATIENT NAME	DATE OF BIRTH	DATE
PATIENT / PARENT PHONE	TESTED WITH	
	☐ Glasses ☐ Contacts ☐ None	
REFERRING DOCTOR	PRACTICE NAME	PRACTICE PHONE / FAX

1	Symptoms	CISS total (front) _____ / 60	Cutoff: 16+ child, 21+ adult	☐ REFER
2	Cover test	Distance _____ Δ exo / eso ☐ Tropia ☐ Vertical Near _____ Δ exo / eso ☐ Tropia ☐ Vertical	Cutoff: near exo 4Δ+ more than distance; any tropia or vertical	☐ REFER
3	NPC	Break _____ cm Recovery _____ cm After 5 repeats _____ cm	Cutoff: break 6 cm or farther, or recedes	☐ REFER
4	Amplitude	OD _____ D OS _____ D OU _____ D	Cutoff: below 15 – 0.25 × age, or 2 D between eyes	☐ REFER
5	Facility ±2.00	OU _____ cpm OD _____ cpm OS _____ cpm Slow side: ☐ Minus ☐ Plus	Cutoff: ages 8–12 under 5 OU / 7 mono; adults under 8 OU / 11 mono	☐ REFER
6	EOMs	Pursuits: ☐ Smooth ☐ Jerky Saccades: ☐ Accurate ☐ Over/under ☐ Head moves	Cutoff: jerky, inaccurate or head movement	☐ REFER

Positive findings (REFER boxes checked) _____ of 6

Notes

☐ **Please call my patient to schedule** (we call within 1 business day)

☐ Send the report to me (with the patient's consent)

Doctor's signature

Date

Fax or email both sides

Fax (561) 462-1245 · Secure email hello@visionlearncenter.com

Or refer online at visionlearncenter.com
Report back within 7 days of the evaluation