# Double vision

Please print this form, check **one box per question**, and bring the completed form to your appointment. These are the questions your neurologist is most likely to ask about this symptom — answering them on paper first makes the visit faster and more accurate. If you are unsure of an answer, check "Not sure".

| Your name | Date of birth | Today's date |
|---|---|---|
| _____ | _____ | _____ |

## 1A. Safety screen

*Answer every question. If any answer is "Yes" or "Not sure", follow the instruction shown below the question — these can be emergencies.*

**Is there sudden visual loss, a curtain or missing field, or a new large shower of floaters or flashes?**

☐ No ☐ Yes ☐ Not sure

If yes: Contact an emergency eye service or emergency department now.

**Is there a painful red eye, halos, vomiting, marked light sensitivity, or pain with eye movement?**

☐ No ☐ Yes ☐ Not sure

If yes: Seek same-day emergency eye assessment; sudden visual loss requires emergency care now.

**Is there new double vision with weakness, severe headache, confusion, imbalance, or difficulty speaking?**

☐ No ☐ Yes ☐ Not sure

If yes: Call emergency services now and record onset or last-known-well time.

**Is there eye protrusion, fever, eyelid swelling, new inability to move the eye, or recent eye trauma?**

☐ No ☐ Yes ☐ Not sure

If yes: Seek emergency eye/orbital assessment now.

## 1B. Timeline

*Use the first occurrence for recurrent episodes and the current episode for a changing symptom.*

**How did the symptom begin?**

☐ Suddenly, over seconds or minutes ☐ Over hours to days ☐ Gradually over weeks or months

☐ Longstanding or since childhood ☐ Not sure

*Use the first occurrence for recurrent episodes; use the current episode for a changing symptom.*

**What is the overall course?**

☐ One persistent episode ☐ Separate recurrent episodes ☐ Steadily worsening ☐ Fluctuating or variable

☐ Currently resolved

**Has this exact pattern been assessed before?**

☐ Definitely new ☐ The same pattern occurred before ☐ Present and stable for a long time ☐ Not sure

## 1C. Discriminating features

**What happens when either eye is covered?**

☐ Double vision disappears with either eye covered ☐ It remains in one eye when the other is covered ☐ Not tested

*Test while looking at a fixed object; do not drive or operate machinery with double vision.*

**When is separation worst?**

☐ Distance viewing or one gaze direction ☐ Near viewing ☐ All directions similarly ☐ Changes with fatigue or time

**Is there a drooping lid, unequal pupil, or limited eye movement?**

☐ Drooping eyelid ☐ Unequal or poorly reactive pupil ☐ Observable limited eye movement ☐ None

**Is there headache, orbital pain, or recent trauma?**

☐ New severe headache or neck pain ☐ Orbital pain or swelling ☐ Recent head/eye trauma ☐ None

## 1D. Associated findings

*Record other clues and the effect on usual activities. New associated symptoms can change urgency.*

**Are there other neurological symptoms—weakness, numbness, speech change, double vision, swallowing difficulty, or severe imbalance?**

☐ Yes ☐ No ☐ Not sure

**Are there systemic clues—fever, weight loss, cancer, infection risk, pregnancy/postpartum status, or a new medication?**

☐ Yes ☐ No ☐ Not sure

**How much does this affect daily activity?**

☐ Noticeable but activities continue ☐ Some activities are limited ☐ Cannot perform usual activities ☐ Not sure

## 1E. Clinical context

*These answers help distinguish medication, medical, neurological, and pre-existing contributors.*

**Who is being assessed?**

☐ Adult or adolescent ☐ Child under 12 ☐ Adult aged 65 or older

**Could a medicine, substance, withdrawal, or recent dose change be relevant?**

☐ No plausible contributor ☐ Yes or possibly ☐ Not reviewed

*Include sedatives, dopamine-blocking drugs, stimulants, decongestants, anticholinergics, alcohol, and non-prescribed substances when relevant.*

**Is there a relevant neurological, muscular, metabolic, cardiovascular, autoimmune, or sleep disorder?**

☐ No known relevant condition ☐ Yes ☐ Not sure

**What prior information is available?**

☐ A previous examination or investigation ☐ Prior records but no clear explanation ☐ No useful prior assessment ☐ Not sure

## 1F. Additional history

Use the lines below to record exact dates and times, witness details, current medications and any recent dose changes, prior tests or investigation reports, and what your usual baseline function is.

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This form collects your history only. It cannot diagnose, triage, or exclude an emergency, and it is not medical advice. Call 911 for severe, sudden, or worsening symptoms.