Steven Locke, MD, DLFAPA
98 Brooks Road
Longmeadow, MA 01106
1-617-283-6699
1-508-213-3776 fax

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Steven.Locke@drstevenlocke.com
www.drstevenlocke.com website
@slockemd twitter
www.doxy.me/drstevenlocke telemedicine

Visual Snow Syndrome (VSS)

Visual Snow Syndrome (VSS) is a neurological condition characterized by a continuous visual disturbance that resembles static or flickering dots across the entire visual field, among other symptoms. Diagnosis is primarily clinical, based on patient history and symptoms, as there is no definitive diagnostic test for VSS. The Visual Snow Syndrome Foundation and some research articles have proposed criteria and symptom checklists that can be used to help diagnose the condition.

Visual Snow Syndrome Questionnaire

Date completed:

Patient Information:

Full Name:

Date of Birth:

Date symptoms started:

Possible triggers for onset:

Visual Symptoms:

Do you see tiny, flickering dots in your visual field that resemble static, like on a detuned TV? Y N

If yes, are these dots present all the time ___ or do they come and go ___?

Are they more noticeable in the dark ___ or in bright light ___?

How would you describe the color of the visual static (e.g., transparent, white, black, multicolored)?

Have you noticed any changes in the intensity of the visual static over time?

Do you experience any of the following additional visual symptoms? (check if YES)

___ Afterimages
___ Trailing images following moving objects
___ Sensitivity to light (photophobia)
___ Seeing halos or starbursts around lights
___ Difficulty seeing at night (nyctalopia)
___ Temporary visual loss (blind spots in the visual field)
___ Other (specify)

How do these visual symptoms affect your daily activities? (Circle one for each function)

Reading: not impaired, mildly impaired, moderately impaired, very impaired

Driving: not impaired, mildly impaired, moderately impaired, very impaired

Working: not impaired, mildly impaired, moderately impaired, very impaired

Social activities: not impaired, mildly impaired, moderately impaired, very impaired

Other Sensory Symptoms:

Do you experience ringing in your ears (tinnitus)? Y N
If YES:
Is it constant ___ or intermittent ___?
Is it in one or both ears? One___ Both___
Have you experienced unusual sensations on your skin (like tingling or numbness)? Y N
Have you noticed any other sensory issues, like:
Sensitivity to sounds ___
Sensitivity to touch? ___
Other?

Neurological Symptoms:

Do you suffer from migraines? Y N
If yes:
How often: daily___ ; 1-2 per week___ ; 1-2 per month___ ; 1-2 per year___ ; less than once a year___
Do they typically come with an aura (visual or sensory disturbances that precede the headache)? Y N
How many migraines in the past year? _____. past month_____?

Have you experienced any cognitive disruptions (e.g., memory issues, trouble concentrating)? Y N
Have you noticed any balance issues or dizziness? Y N

Medical History:

Have you ever used hallucinogenic or psychedelic drugs, even just once?
(LSD, mushrooms, psilocybin, MDMA or Ecstasy, peyote or mescaline, DMT, etc.) Y N

Have you ever used cannabis in any form (smoked it or used edibles)? Y N

Is there any history of Visual Snow Syndrome or other neurological conditions in your family? Y N. Explain:

Have you been exposed to any potential triggers for visual disturbances, such as medications, drugs, or toxins? Y N
Have you recently suffered from an infection, head injury, or any other illness? Y N
If yes, explain:

Diagnostic testing:

Have you undergone any testing? (Provide dates, mo/yr)

Ophthalmology exam ___
Neurological exam____
MRI ___
X-Rays
CT scan ___
EEG ___
Blood tests ___ (which?)
Neuropsychological testing ___
Other exams, and indicate results, if known.

Lifestyle and Environment:

Describe your typical daily screen time and the type of screens you use.

How often do you experience eye strain? Never, rarely, often, very often (circle one)
Do you wear corrective lenses? Y N
What is your average level of stress (0 to 10) on a regular basis, and how do you typically manage it?

Average stress level (past two weeks) ____ (0-10) Zero = no stress

How many hours do you sleep on average per night? _____. # of awakenings? ____

Impact on Quality of Life:

How has Visual Snow Syndrome affected your quality of life and mental health (e.g., anxiety, depression)?

Has VSS affected your professional ____ and/or social life ___? (Y N)

How?

What measures have you taken to alleviate your symptoms?

Have any been effective?

Does anything make your VSS symptoms worse?

Healthcare Consultation:

Have you consulted with any healthcare professionals about these symptoms? Y N
If yes, please provide details.

Have you received any treatment for your VSS?

Medications ___ (list all) (Helpful?) (side-effects?)

Talk therapy? Y N

CBT ___

Not sure ___

Other ___

Complementary therapies (helpful or not-helpful?)

Acupuncture ___

Yoga ___

Exercise ___

Neurofeedback/biofeedback ___

Herbal remedies ___ (which?) (Helpful?) (side-effects?)

Nutritional supplements ___ (which?) (Helpful?) (side-effects?)

Other therapies?

Comments:

Please bring this completed questionnaire to your healthcare provider for further evaluation and diagnosis. The diagnosis of Visual Snow Syndrome is complex and typically involves ruling out other conditions, so detailed information is crucial for accurate diagnosis and management.

Remember, this questionnaire is not a substitute for professional medical advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health provider with any questions you may have regarding a medical condition.