



Patient Name \_\_\_\_\_

**VISUAL FUNCTIONING**

Do you have difficulty, even with glasses, with the following activities?

	<u>Right Eye</u>		<u>Left Eye</u>	
	YES	NO	YES	NO
1. Reading small print, such as labels on medicine bottles, telephone books or food labels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Reading a newspaper or book?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Reading a large print newspaper or large numbers on a telephone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Seeing steps, stairs or curbs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Reading traffic signs, street signs or store signs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Doing fine handwork like sewing, knitting, or carpentry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Writing checks or filling out forms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Taking part in sports like bowling, tennis or golf?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Watching television?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SYMPTOMS**

Have you been bothered by:

1. Poor night vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Seeing rings or halos around lights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Glare caused by headlights or bright sunlight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Hazy and/or blurry vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**DRIVING**

Please circle

1. Do you currently drive a car?	Yes	No
2. Do you have difficulty driving during the day because of your vision?	Yes	No
3. Do you have difficulty driving at night because of your vision?	Yes	No

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Tech Initial \_\_\_\_\_