Patient Name________________________________

VISUAL FUNCTIONING **Do you have difficulty, even with glasses, with the following activities?**	***Right Eye*** **YES**	 **NO**	***Left Eye*** **YES**	 **NO**
1. Reading small print, such as labels on medicine bottles, telephone books or food labels?				
2. Reading a newspaper or book?				
3. Reading a large print newspaper or large numbers on a telephone?				
4. Seeing steps, stairs or curbs?				
5. Reading traffic signs, street signs or store signs?				
6. Doing fine handwork like sewing, knitting, or carpentry?				
7. Writing checks or filling out forms?				
8. Taking part in sports like bowling, tennis or golf?				
9. Watching television?				

SYMPTOMS
Have you been bothered by:

1. Poor night vision?
2. Seeing rings or halos around lights?
3. Glare caused by headlights or bright sunlight?
4. Hazy and/or blurry vision?

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________