Patient: _____DOB: _____

PLEASE CIRCLE YOUR RESPONSE ON EACH LINE
(Leave the line blank if it does not apply)

HAVE YOU BEEN BOTHERED BY:				**COMMENT**
Overall decline in vision	A little	Some	A lot	
Blurry vision	A little	Some	A lot	
Glare or poor night vision	A little	Some	A lot	
Sensitivity to light	A little	Some	A lot	
Seeing rings or halos around lights	A little	Some	A lot	
Seeing double	A little	Some	A lot	
Writing out checks or filling out forms	A little	Some	A lot	

DO YOU HAVE DIFFICULTY, EVEN WITH GLASSES:				**COMMENT**
Driving during daylight hours?	A little	Some	A lot	
Driving during evening/night hours?	A little	Some	A lot	
Seeing traffic lights or signals?	A little	Some	A lot	
Seeing steps, stairs or curbs?	A little	Some	A lot	
Reading a newspaper, or phone book?	A little	Some	A lot	
Reading labels, price tags or medication Bottles?	A little	Some	A lot	
Using a computer?	A little	Some	A lot	
Doing fine handwork or hobbies?	A little	Some	A lot	
Looking at colors?	A little	Some	A lot	
Sewing, cooking or working around the house?	A little	Some	A lot	
Playing cards?	A little	Some	A lot	
Watching TV?	A little	Some	A lot	
Looking at steps or curbs?	A little	Some	A lot	
Working at your job?	A little	Some	A lot	
Trying to recognize people?	A little	Some	A lot	
Looking out of only one eye?	A little	Some	A lot	
Other: _____	A little	Some	A lot	

Patient's Signature: _____Date: _____