Patient Questionnaire Patient Name_____

Please Check Eye(s) with Symptoms:

Left ☐ Right ☐

VISUAL FUNCTIONING

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

YES	NO	
		Reading small print, such as labels on medicine bottles, food labels or text on a smartphone?
		Reading a newspaper, book or tablet?
		Reading a large-print book, large print newspaper or large numbers on a telephone?
		Recognizing people when they are close to you?
		Seeing steps, stairs or curbs?
		Reading traffic signs, street signs or store signs?
		Doing fine handwork like sewing, knitting, crocheting, or carpentry?
		Writing checks or filling out forms?
		Playing games such as bingo, dominos, or card games?
		Taking part in sports like bowling, handball, tennis, or golf?
		Cooking?
		Watching television or looking at a computer/laptop screen?

SYMPTOMS

Have you been bothered by:

YES	NO	
		Poor night vision?
		Seeing rings or halos around lights?
		Glare caused by headlights or bright sunlight?
		Hazy and/or blurry vision?
		Night Driving?
		Day Driving?
		Seeing well in poor or dim light?
		Poor color vision?
		Double Vision?

Patient Signature

_____

Date

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