

## Visual Function Questionnaire

*Please Check All That Apply to You*

Have you been bothered by:

- |  |  |
|--|--|
| <input type="checkbox"/> Blurry vision     | <input type="checkbox"/> Seeing in poor or dim light         |
| <input type="checkbox"/> Hazy vision       | <input type="checkbox"/> Halos                               |
| <input type="checkbox"/> Glare             | <input type="checkbox"/> Seeing rings or stars around lights |
| <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Frequent changes in glasses         |

Have you noticed difficulty with your vision when you:

- |  |   |
|--|---|
| <input type="checkbox"/> Work at your job        | <input type="checkbox"/> Shop for groceries               |
| <input type="checkbox"/> Manage your home        | <input type="checkbox"/> Drive during daylight hours      |
| <input type="checkbox"/> Get around in your home | <input type="checkbox"/> Drive during evening/night hours |
| <input type="checkbox"/> Watch TV                | <input type="checkbox"/> See traffic signs                |
| <input type="checkbox"/> Use a computer          | <input type="checkbox"/> Sew or do crafts                 |
| <input type="checkbox"/> Read newspapers         | <input type="checkbox"/> Play golf                        |
| <input type="checkbox"/> Read the telephone book | <input type="checkbox"/> Enjoy recreation or leisure      |
| <input type="checkbox"/> Read labels             | <input type="checkbox"/> Recognize people                 |
| <input type="checkbox"/> Read price tags         | <input type="checkbox"/> Other _____                      |

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_