For Office Use Only
Patient Name:_____
Date of Procedure:_____
Operative Eye: __ RT __ LT
❒Pre-Procedure ❒Post-Procedure

Visual Function Questionnaire

To give us a better idea of how to help improve your visual problem(s), please provide us with the following information.

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

	CIRCLE ONE		IF YES, CIRCLE BELOW		
Reading small print	YES	NO	MILD	MODERATE	SEVERE
Reading labels on medicine bottles	YES	NO	MILD	MODERATE	SEVERE
Reading a telephone book	YES	NO	MILD	MODERATE	SEVERE
Reading food labels	YES	NO	MILD	MODERATE	SEVERE
Reading a newspaper or books	YES	NO	MILD	MODERATE	SEVERE
Seeing steps, stairs, or curbs	YES	NO	MILD	MODERATE	SEVERE
Reading traffic signs, street signs or store signs	YES	NO	MILD	MODERATE	SEVERE
Doing fine handwork like sewing, knitting, crocheting or carpentry	YES	NO	MILD	MODERATE	SEVERE
Writing checks or filling out forms	YES	NO	MILD	MODERATE	SEVERE
Playing games such as bingo, dominos, card games or mahjong	YES	NO	MILD	MODERATE	SEVERE
Watching television	YES	NO	MILD	MODERATE	SEVERE

Have you been bothered by:

Poor night vision	YES	NO
Seeing rings around lights	YES	NO
Glare	YES	NO
Hazy vision	YES	NO
Do you have difficulty driving at night?	YES	NO
Do you have difficulty driving during the day?	YES	NO
Does your vision seem blurry in poor or dim light?	YES	NO

Patient Signature:_____Date:_____

Name:_____