Visual Functioning Questionnaire

To help us evaluate your level of visual functioning it is important to know the problems you are having as you go through your daily activities.

Please circle answer YES or NO

Does your sight make it a problem for you to:

Read newspapers or telephone books	YES	NO
See traffic signs or store aisle directories	YES	NO
Read your letter and bills	YES	NO
Read price tags or medicine labels	YES	NO
Recognize people's faces	YES	NO
See stair steps or curbs	YES	NO
See TV clearly	YES	NO
Manage your home	YES	NO
Do your favorite hobby	YES	NO
Enjoy recreation and leisure	YES	NO

Are you bothered by:

Headlight glare from cars	YES	NO
Halos around light at night	YES	NO
Glare from glossy magazines	YES	NO
Bright sunlight when outside	YES	NO
Facing windows with bright daylight	YES	NO
Hazy, foggy or blurry vision	YES	NO

If stronger glasses won't improve your vision anymore and if the only way to help you see better is cataract surgery, do you feel your vision problem is bad enough to consider cataract surgery now? YES NO

Patient Name (print): _____Date:_____
Patient Signature: _____
Physicians Signature: _____