



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: _____