

Vision Questionnaire:

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

1. Reading small print, such as labels on medicine bottles or food labels? YES NO
2. Reading newspapers or books? YES NO
3. Reading a large print book, large print newspaper, or large numbers? YES NO
4. Recognizing people when they are close to you? YES NO
5. Seeing steps, stairs, or curbs? YES NO
6. Reading traffic signs, street signs, or store signs? YES NO
7. Performing fine handwork like sewing, knitting or carpentry? YES NO
8. Writing checks or filling out forms? YES NO
9. Playing games such a bingo, dominos or card games? YES NO
10. Taking part in sports like bowling, handball, tennis or golf? YES NO
11. Cooking? YES NO
12. Watching TV? YES NO

Have you been bothered by?

1. Poor night vision? YES NO
2. Seeing rings or halos around lights? YES NO
3. Glare caused by headlights or bright sunlight? YES NO
4. Hazy and/or blurry vision? YES NO
5. Seeing well in poor or dim lights? YES NO
6. Poor color vision? YES NO
7. Double vision? YES NO

Driving:

1. Have you ever driven a car? YES NO
2. Are you currently driving? YES NO
3. If no, when did you stop driving? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. How much difficulty do you have during the day because of your vision?

 None Mild Moderate Significant

1. How much difficulty do you have driving at night because of your vision?

 None Mild Moderate Significant

I certify that I have reviewed the information listed above and confirm that it is true and correct to the best of my knowledge. I authorize Cool Springs Surgical Associates to bill any medical insurance. I understand and agree that I will be responsible for all charges not covered by my insurance.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_