

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: _____