Visual Function Questionnaire

VISUAL FUNCTIONING - Does your sight make it a problem for you to:

	Alwove	Sometimes	Novor	Don't Know		Alwove	Sometimes	Novor	Don't Know
Dood now on one	<u> </u>	\bigcirc	$\overline{\mathbf{O}}$	\sim	Saastana	\sim	\bigcirc	\bigcirc	
Read newspapers	\mathbf{O}	\mathbf{O}	\mathbf{O}	O	See steps	O	\mathbf{O}	\mathbf{O}	\cup
Read medicine bottle	О	\mathbf{O}	Ο	0	See cracks in the	О	О	Ο	0
labels					sidewalk				
Read a telephone book	О	О	Ο	О	See out of your other eye	e O	О	Ο	О
See traffic lights or street	t O	О	Ο	О	Watch TV	О	О	Ο	О
signs					Work at your job	О	О	Ο	О
Sew or crochet	0	0	Ο	О	Manage your home	0	О	Ο	О
Read labels	Ο	0	Ο	О	Enjoy recreation and	О	О	Ο	О
Read price tags	О	О	Ο	Ο	leisure				
Recognize people	О	О	О	О					

SYMPTOMS - Have you been bothered by:

	Always	Sometimes	Never	Don't Know		Always	Sometimes	Never	Don't Know
Poor night vision	Ō	О	Ο	О	Poor vision in	Ō	О	Ο	О
Seeing rings or halos	s O O O inadequate or dim light								
around lights					Difficulty with color	0	О	Ο	0
Glare	О	0	Ο	О	vision				
Hazy vision	Ο	0	Ο	Ο	Difficulty with depth	Ο	О	Ο	О
Blurry vision	Ο	0	Ο	Ο	perception				
					Headlights from	О	О	Ο	О
					automobiles				

Don't

DRIVING AND ACCIDENTS

Do you drive?	O YES	O NO
Are you currently able	e to drive?	

AlwaysSometimesNeverKnowDuring daylight hoursOOODuring evening/night
hoursOOO

Do problems with your sight cause you to be fearful when you drive?

				Don't
P	Always	Sometimes	Never	Know
During daylight hours	Ο	О	Ο	Ο
During evening/night hours	0	Ο	0	О
During the past 6 months,		О	0	О
have you made any dr	iving e	errors?		

Patient Signature_	

Doctor's Assessment:

O Surgery not indicated.

O Surgery indicated based upon patient's compliants and established objective criteria.

_____ Date_____

____ Date ____

Physician's Signature _____

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