Visual Assessment

Patient Name:_______________________________ DOB: ______________ Date:_____________

1. **Does your vision with glasses make it a problem for you to:**

(Select only one description from each row)

	Not at all	Somewhat	A lot
A. Read Traffic signs	1	2	3
B. Drive during the daytime	1	2	3
C. Drive at night	1	2	3
D. See steps or curbs	1	2	3
E. Read labels on medicine bottles	1	2	3
F. Read a magazine/newspaper/book/phone	1	2	3
G. Watch television/use computer	1	2	3
H. Do household chores or hobbies (cooking, cleaning, sewing, cards, fine handiwork, etc)	1	2	3

2. **How much are you bothered by the following:**

(Select only one description from each row)

	Not at all	Somewhat	A lot
A. Walking outside on a sunny day	1	2	3
B. Driving towards the sun	1	2	3
C. Driving toward oncoming headlights (glare)	1	2	3
D. Seeing halo's around lights	1	2	3
E. Seeing in poor or dim light	1	2	3