Assessment of Visual Function

Date
Patient Name
Which eye do you think needs cataract surgery? ☐Right ☐Left (check one)
What specific improvements in your daily life do you hope to gain with surgery?
Reason for exam today (in your own words)

Visual Functional Status (complete all lines)	Check Response
1. Do you have difficulty seeing street signs or driving? (curbs, freeway exits, traffic lights, halos/glare around lights)	☐YES ☐NO
2. Do you have difficulty seeing TV or movies? (faces, numbers, or printing)	☐YES ☐NO
3. Do you have difficulty reading small print with good light, blinking, and proper glasses? (books, newspaper, telephone book, medicine labels, instructions)	☐YES ☐NO
4. Do you have difficulty performing detailed work? (sewing, knitting, crocheting, embroidery, baiting a fish hook, or other fine task)	☐YES ☐NO
5. Do you difficulty with personal correspondences? (writing checks, reading bills, filling out forms)	☐YES ☐NO
6. Do you difficulty with leisure activities such as sports or hobbies? (playing card games, bingo, dominoes, or sport activities such as bowling, hunting, golf, tennis, other _____)	☐YES ☐NO
7. Do you have visual difficulty functioning around the house? (cooking, ironing, general household upkeep, climbing steps or curbs, dialing the telephone, telling time on a watch, using public transportation)	☐YES ☐NO
8. Are you unable to see and recognize faces of other people? (in church, grocery store, clubs, and other daily activities)	☐YES ☐NO
9. If you live alone and wish to remain independent, are you unable to care for yourself with your present vision?	☐YES ☐NO

Do you have any of the following **VISUAL SYMPTOMS?**	
1. Double or distorted vision?	☐YES ☐NO
2. Glare, halos, rings around lights?	☐YES ☐NO
3. Difficulty with color perception?	☐YES ☐NO
4. Difficulty with depth perception?	☐YES ☐NO
5. Worsening of vision – blurred vision?	☐YES ☐NO

Anything we did not ask?_____

Patient Signature_____