

VISUAL ASSESSMENT

PATIENT NAME : _____ DOB: _____

VISUAL FUNCTIONING

Do you have difficulty, with your glasses, doing the following activities ?

1. Reading small print, such as newspaper print, medicine bottles or telephone book? YES NO
2. Reading large-print books? YES NO
3. Reading traffic signs or street signs at a distance? YES NO
4. Difficulty driving at night ? YES NO
5. Difficulty driving during the day? YES NO

SYMPTOMS

Have you been bothered by:

1. Rings or halos around lights? YES NO
2. Glare caused by headlights or bright lights? YES NO
3. Decreased color vision? YES NO

Visual Goal

1. Do you dislike wearing glasses? YES NO
2. Do you wish to eliminate the need for glasses? YES NO
3. Do you dislike the idea of wearing reading glasses? YES NO
4. Are you aware that there are implants available to you to help eliminate or decrease the need for glasses after surgery? YES NO

Did you need assistance filling out this form because of your vision? YES NO

SIGNATURE _____ DATE _____