ATLANTIC EYE

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FUNCTIONAL VISION SCREENING QUESTIONNAIRE

To best serve you and your vision care needs, please complete the following visual questionnaire. By completing this document, our team of vision care experts will be able to better understand and accommodate your desired lifestyle and vision goals.

Patient Name: _____ Male ○ Female ○

Date of Birth: _____ /_____ /_____ Age: _____ Telephone: _____

Email: _____

Occupation: _____

Hobbies: _____

HOW MUCH OF A VISION PROBLEM DO YOU HAVE WITH… NONE 0 — SEVERE 4

Glare from sunlight while driving	N/A ○	0 ○	1 ○	2 ○	3 ○	4 ○
Glare around headlights in a car after dark	N/A ○	0 ○	1 ○	2 ○	3 ○	4 ○
Difficulty reading street signs far away	N/A ○	0 ○	1 ○	2 ○	3 ○	4 ○
Difficulty reading for long periods of time	N/A ○	0 ○	1 ○	2 ○	3 ○	4 ○
Difficulty reading with your glasses in dim light	N/A ○	0 ○	1 ○	2 ○	3 ○	4 ○
Difficulty with vision for sports (following a golf ball, tennis ball)	N/A ○	0 ○	1 ○	2 ○	3 ○	4 ○
Difficulty with hobbies requiring fine vision (sewing, carpentry)	N/A ○	0 ○	1 ○	2 ○	3 ○	4 ○
Difficulty seeing small captions on the tv	N/A ○	0 ○	1 ○	2 ○	3 ○	4 ○
Difficulty reading fine print (medicine bottles, food labels)	N/A ○	0 ○	1 ○	2 ○	3 ○	4 ○

Do you drive after dark? (fill the circle)

○ Often ○ Sometimes ○ Rarely

Do you use a computer? (fill the circle)

○ Often ○ Sometimes ○ Rarely

Do you do a lot of close detail work, like sewing or building models? (fill the circle)

○ Often ○ Sometimes ○ Rarely

If you had to wear glasses after surgery for one activity, for which activity would you be most willing to wear glasses? (fill the circle)

○ Reading ○ Computer ○ Driving ○ Never/Rarely as Possible

_____ _____/_____/_____

Patient Signature Date