Visual Function Assessment

Patient Name:_____ **Date of Birth:**_____**Date:**_____

Have you had any eye surgery and /or procedures? (Please check which eye): ❑ **Right** ❑ **Left** ❑ **Both**

Are you having vision problems (Please circle which eye): ❑ **Right** ❑ **Left** ❑ **Both**

Reason for exam today (patient's words):_____

_____

_____

	Visual Function Status (check Yes OR No for each question)	**Yes**	**No**
1.	Do you have difficulty seeing well enough to drive safely? (street signs, curbs, freeway exits, traffic lights, halos/glare around lights)	❑	❑
2.	Do you have difficulty seeing a TV or movie screen? faces, numbers, or printing)	❑	❑
3.	Do you have difficulty reading small print with good light, complete blinking and proper glasses? (books, newspaper, telephone book, medicine labels, instructions)	❑	❑
4.	Do you have difficulty performing detailed work? (sewing, knitting, crocheting, embroidery, baiting a fish hook, or other fine tasks)	❑	❑
5.	Do you have difficulty with correspondences? (writing checks, reading bills, filling out forms)	❑	❑
6.	Do you have difficulty with leisure activities, such as sports or hobbies? (card games, bingo, dominoes, bowling, hunting, golf, tennis)	❑	❑
7.	Do you have visual difficulty while performing tasks? (cooking, housekeeping, climbing steps or curbs, dialing the telephone, telling time on a watch, using public transportation)	❑	❑
8.	Do you have difficulty recognizing faces of people? (in church, grocery store, clubs, and other daily activities)	❑	❑
9.	If you live alone and wish to remain independent, are you unable to care for yourself with your present vision?	❑	❑

	Do you have any of the following VISUAL SYMPTOMS? (check Yes OR No for each question)	**Yes**	**No**
1.	Double or distorted vision?	❑	❑
2.	Glare, halos, rings around lights?	❑	❑
3.	Difficulty with color perception?	❑	❑
4.	Difficulty with depth perception?	❑	❑
5.	Worsening of vision - blurred vision?	❑	❑

Patient Signature:_____ **Date:**_____

Reviewed by Physician:_____ **Date:**_____

QUALITY OF VISION AT DIFFERENT RANGES

This checklist will help us to provide the treatment best suited for your visual needs. It is important that you understand that many patients still need to wear glasses for some activities after surgery. However, due to recent advances, we are now able to offer the possibility for you to either be free from the need for glasses, or at least significantly reduce the need for glasses at some ranges.

1. Are you interested in seeing well at distance without glasses after cataract surgery?

❑ Yes, I prefer to not need distance glasses ❑ Not important to me

2. Are you interested in seeing well up-close without glasses after surgery?

❑ Yes, I prefer to not need reading glasses ❑ Not important to me

Zone 1	**Zone 2**	**Zone 3**
Reading	Shaving	Driving
Sewing	Cooking	Golfing
Applying make-up	Computer Use	Watching TV
Working crossword puzzles	Reading labels on shelf	Movie theatre

3. Which "Zone of Vision" is most important to you? (Please choose only one option.)

❑ Zone 1 ❑ Zone 2 ❑ Zone 3

4. For which zone would you be most willing to wear glasses after surgery?

❑ Zone 1 ❑ Zone 2 ❑ Zone 3

5. How important would it be for you to be free from glasses for your daily activities?

❑ Very important ❑ Moderately important ❑ Not important

Cataract surgery can almost always be safely postponed until you feel you need better vision. If a new glass prescription won't improve your vision anymore, and if the only way to help you see better is cataract surgery, do you feel your vision problem is bad enough to consider cataract surgery?

❑ Yes ❑ No