CARTER EYE CENTER

VISUAL ACUITY QUESTIONNAIRE

Name _____ Account # _____

Date of exam _____ Date of procedure _____ Scheduled procedure _____

❍ Cataract sx ❍ Ptery. Exe. Sx. ❍ Other _____

❍ YLPC s/p cat. sx. ❍ YLPC s/p AIOL ❍ Other _____

Activity of daily living complaint _____

EYE	DISTANCE VA	BEST CORRECTED SNELLEN VA	NEAR VA	BAT OR GLARE SYMPTOMS
OD	SC / CC 20/	20/	SC / CC J	20/
OS	SC / CC 20/	20/	SC / CC J	20/

VISUAL FUNCTIONAL STATUS AND VISUAL SYMPTOMS

1. Do you have difficulty seeing street signs and/or driving? ❍ Yes ❍ No ❍ N/A
   (problems with halos/glare around lights, seeing curbs, exits)
2. Do you have difficulty see the TV screen or movies? ❍ Yes ❍ No ❍ N/A
   (faces, numbers or printing on screen)
3. Do you have difficulty reading small print with good light and proper glasses? ❍ Yes ❍ No ❍ N/A
   (newspaper, medicine labels, books)
4. Do have difficult performing handwork? ❍ Yes ❍ No ❍ N/A
   (sewing, knitting, fine tasks)
5. Do you have difficulty with personal correspondence? ❍ Yes ❍ No ❍ N/A
   (writing checks, reading bills, filling out forms)
6. Do you have difficulty with leisure activities? ❍ Yes ❍ No ❍ N/A
   (playing cards, bingo, golf, sporting activities)
7. Do you have visual difficulty with navigation around the house? ❍ Yes ❍ No ❍ N/A
   (climbing steps, dialing the telephone, telling time on watch, using public transportation)
8. Are you able to recognize faces of people? ❍ Yes ❍ No ❍ N/A
9. Do you have double or distorted vision? ❍ Yes ❍ No ❍ N/A
10. Difficulty with color perception? ❍ Yes ❍ No ❍ N/A
11. Difficulty with depth perception? ❍ Yes ❍ No ❍ N/A
12. Are you able to care for yourself with your present vision? ❍ Yes ❍ No ❍ N/A
13. Do you live alone and wish to remain independent? ❍ Yes ❍ No ❍ N/A