Visual Function Questionnaire

Please Check All That Apply to You

Have you been bothered by:

____ Blurry vision
____ Hazy vision
____ Glare
____ Poor night vision
____ Seeing in poor or dim light
____ Halos
____ Seeing rings or stars around lights
____ Frequent changes in glasses

Have you noticed difficulty with your vision when you:

____ Work at your job
____ Manage your home
____ Get around in your home
____ Watch TV
____ Use a computer
____ Read newspapers
____ Read the telephone book
____ Read labels
____ Read price tags
____ Shop for groceries
____ Drive during daylight hours
____ Drive during evening/night hours
____ See traffic signs
____ Sew or do crafts
____ Play golf
____ Enjoy recreation or leisure
____ Recognize people
____ Other _____

Patient signature: _____

Date: _____ Reviewed by: _____