Hattiesburg Eye Clinic, P.A.

Date: ______________________

Patient Name: ____

Reason for exam today ____

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Functional Vision Status with Glasses or contacts

DO YOU HAVE DIFFICULTY WITH THE FOLLOWING:

1. Seeing street signs or to drive? (curbs, freeway exits, traffic light, halos/glare around lights)	YES	NO
2. Watching TV or movies? (faces, numbers or printing)	YES	NO
3. Reading small print with good light, complete blinking and proper lighting? (books, newpapers, telephone books, etc.)	YES	NO
4. Performing detailed work? (sewing, knitting, crocheting, embroidery, baiting a fish hook or other fine tasks)	YES	NO
5. With person correspondence? (writing checks, reading bills or filling out forms)	YES	NO
6. With leisure activities such as sports or hobbies? (playing card games, bingo, dominoes or activities such as bowling, hunting or golf)	YES	NO
7. Functioning around the house? (cooking, ironing, general household upkeep, climbing steps or curbs, dialing the telephone telling time on a clock)	YES	NO
8. Recognizing faces of people? (church, grocery store, clubs, etc.)	YES	NO
9. If you live alone and wish to remain independent are you unable to care for yourself with your present vision?	YES	NO

Visual Symptoms

Double or distorted vision	YES	NO
Glare, halos or rings around lights	YES	NO
Difficulty with color perception	YES	NO
Worsening of blurred vision	YES	NO

Patient Signature: ____