

SPINAK MEDICAL EYE CENTER

FUNCTIONAL VISUAL NEEDS

PATIENT NAME: _____ Date: _____

<u>With your glasses on, do you have difficulty with...</u>	<u>YES</u>	<u>NO</u>
1. Reading small print such as a newspaper, a book, or labels?	()	()
2. Recognizing people when they are close to you?	()	()
3. Judging distances, seeing steps, stairs, or curbs?	()	()
4. Reading traffic signs, street signs, or store signs?	()	()
5. Fine handwork like sewing, knitting, or carpentry?	()	()
6. Writing checks or filling out forms?	()	()
7. Playing games like bingo, dominos or cards?	()	()
8. Taking part in sports like hunting, golf or tennis?	()	()
9. Cooking or watching TV?	()	()
10. Do you drive a car? If no, did you stop because of your vision?	() ()	() ()
11. Driving during the day because of your vision?	()	()
12. Driving at night because of your vision?	()	()
13. Seeing on a sunny day or with a glare at night?	()	()
14. Other: _____	()	()

Questions to identify potential Dry Eye patients:

	<u>few times/week</u>	<u>2 times/day</u>	<u>more than 2 times/day</u>
1. How often do you use artificial tears?	()	()	()
	<u>Sometimes</u>	<u>Often</u>	<u>Always</u>
2. Do your eyes feel dry, painful, or sore?	()	()	()
3. Do you experience episodes of blurred vision?	()	()	()
4. How often are your eyes sensitive to light?	()	()	()
5. Do you have problems with your eyes when you are working on a computer, watching TV, or reading?	()	()	()