SPINAK MEDICAL EYE CENTER
FUNCTIONAL VISUAL NEEDS

PATIENT NAME: ___________________________________

DATE	DATE	DATE	DATE

Do you have difficulty with (with and/or without glasses on)…	**YES**	**NO**
Reading small print such as a newspaper, book or labels?		
Recognizing people when they are close to you?		
Judging distances or seeing steps, stairs or curbs?		
Reading traffic signs, street signs or store signs?		
Fine handwork like sewing, knitting, carpentry, writing checks or filling out forms?		
Playing games like bingo, dominoes or cards?		
Taking part in sports like hunting, golf or tennis?		
Cooking or watching TV?		
Do you drive a car?		
If no, did you stop because of your vision?		
Driving during the day because of your vision?		
Driving at night because of your vision?		
Seeing on a sunny day or with a glare at night?		

Report the <u>FREQUENCY</u> of your symptoms using the rating system below:

0 = Never 1 = Sometimes 2 = Often 3 = Constant

Symptoms:	**0**	**1**	**2**	**3**
Dryness, grittiness or scratchiness				
Soreness, pain or irritation				
Burning, watering or light sensitivity				
Eye fatigue or blurred vision				
Any of the above while reading, watching TV or working on the computer				

Report the <u>SEVERITY</u> of your symptoms using the rating system below:

0 = No Problems

1 = Tolerable – not perfect but not uncomfortable

2 = Uncomfortable – irritating but does not interfere with my day

3 = Bothersome – irritating and interferes with my day

4 = Intolerable – unable to perform my daily tasks

Symptoms:	**0**	**1**	**2**	**3**	**4**
Dryness, grittiness or scratchiness					
Soreness, pain or irritation					
Burning, watering or light sensitivity					
Eye fatigue or blurred vision					
Any of the above while reading, watching TV or working on the computer					

Have you ever considered cosmetic surgery on your eyelids? Yes or No