LEFT EYE VISUAL ASSESSMENT

PATIENT NAME ______________________ DATE __________

VISUAL FUNCTIONING **Does your vision cause a problem for you to . . .**

Read A Newspaper	❏ Always	❏ Sometimes	❏ Never
Read Cell Phone/Tablet	❏ Always	❏ Sometimes	❏ Never
See Traffic Signs	❏ Always	❏ Sometimes	❏ Never
Read Labels	❏ Always	❏ Sometimes	❏ Never
Read Price Tags	❏ Always	❏ Sometimes	❏ Never
Recognize People	❏ Always	❏ Sometimes	❏ Never
See Steps	❏ Always	❏ Sometimes	❏ Never
See Street Curbs When Walking	❏ Always	❏ Sometimes	❏ Never
Watch TV	❏ Always	❏ Sometimes	❏ Never
Work At Your Job	❏ Always	❏ Sometimes	❏ Never
Manage Your Home	❏ Always	❏ Sometimes	❏ Never
Enjoy Recreation & Leisure	❏ Always	❏ Sometimes	❏ Never

SYMPTOMS **Have you been bothered by any of the following?**

Difficulty reading	❏ Always	❏ Sometimes	❏ Never
Difficulty seeing computer screen	❏ Always	❏ Sometimes	❏ Never
Poor night vision	❏ Always	❏ Sometimes	❏ Never
Seeing halos around lights	❏ Always	❏ Sometimes	❏ Never
Glare	❏ Always	❏ Sometimes	❏ Never
Blurry, hazy vision	❏ Always	❏ Sometimes	❏ Never
Difficulty seeing in poor or dim light	❏ Always	❏ Sometimes	❏ Never

DRIVING

Are you currently able to drive? ❏ Yes ❏ No

If so, during daylight hours ❏ Yes ❏ No If so, during evening hours ❏ Yes ❏ No

Do problems with your sight cause you to be afraid when you drive?

During Daylight Hours ❏ Yes ❏ No During Evening Hours ❏ Yes ❏ No

During the past six months, have you made any driving errors? ❏ Yes ❏ No

OCCUPATION ______________________

INTERESTS / HOBBIES ______________________

PATIENT SIGNATURE ______________________ **TECH INITIALS** __________

EYE CENTER OF TEXAS
Leaders in Eye Care

Revised 5/2023