Eye Center of Texas - Visual Assessment

Patient Name:_____DATE: _____

VISUAL FUNCTIONING: Does your vision cause a problem for you to?

	ALWAYS	*SOMETIMES*	*NEVER*
Read Newspaper:	_____	_____	_____
Read A Telephone Book:	_____	_____	_____
See Traffic Signs:	_____	_____	_____
Read Labels:	_____	_____	_____
Read Price Tags:	_____	_____	_____
Recognize People:	_____	_____	_____
See Steps:	_____	_____	_____
See Cracks In Sidewalk:	_____	_____	_____
Watch TV:	_____	_____	_____
Work At Your Job:	_____	_____	_____
Manage Your Home:	_____	_____	_____
Enjoy Recreation & Leisure:	_____	_____	_____

SYMPTOMS: Have you been bothered any of the following?

	ALWAYS	*SOMETIMES*	*NEVER*
Difficulty reading:	_____	_____	_____
Difficulty seeing computer screen	_____	_____	_____
Poor night vision:	_____	_____	_____
Seeing halo's around lights:	_____	_____	_____
Glare:	_____	_____	_____
Blurry, hazy vision:	_____	_____	_____
Difficulty seeing in poor or dim light:	_____	_____	_____

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: _____

INTEREST / HOBBIES: _____

_____ _____
Patient's Signature **Tech Initials**