EYE CENTER OF TEXAS
Leaders in Eye Care

VISUAL ASSESSMENT

PATIENT'S NAME _____ DATE _____

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

Read Newspaper	❑ Always	❑ Sometimes	❑ Never
Read A Telephone Book	❑ 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 Cracks In Sidewalk	❑ 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 any of the following?

Difficulty reading	❑ Always	❑ Sometimes	❑ Never
Difficulty seeing computer screen	❑ Always	❑ Sometimes	❑ Never
Poor night vision	❑ Always	❑ Sometimes	❑ Never
Seeing halo's 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 _____

INTEREST / HOBBIES _____

PATIENT'S SIGNATURE _____ TECH INITIALS _____