Pre-Operative Visual Function Form

Patient Name: _____ DOB: _____ Gender: M F
(please print)

***For Office Use Only**

☐	Pre-op First Eye Cataract	☐ OD	☐ OS
☐	Pre-op Second Eye Cataract	☐ OD	☐ OS
☐	Secondary PCO/Pre-YAG	☐ OD	☐ OS

Review of Systems and Medications List updated: Yes No

Please check <u>Yes</u> or <u>No</u> if you are experiencing any difficulty with the following:

	Yes	No	Comments
1. Reading small print, such as labels on medicine bottles, a telephone book or food labels.			
2. Reading newspaper or book.			
3. Reading a large-print book or large-print newspaper or numbers on a telephone.			
4. Recognizing people when they are close to you.			
5. Seeing steps, stairs or curbs.			
6. Reading traffic signs, street signs or store signs.			
7. Doing fine handiwork like sewing, knitting, crocheting or carpentry.			
8. Writing checks or completing forms.			
9. Playing games such as bingo, cards or dominos.			
10. Taking part in sports such as golf, tennis or handball.			
11. Difficulty with cooking.			
12. Bothered by glare/halos.			
If yes, describe what circumstances:			
13. Difficulty watching TV.			
14. Do you currently drive a car?			
15. Do you have difficulty driving during the day because of your vision?			
16. Are you bothered by glare from lights at night?			
17. Do you have difficulty driving at night because of your vision?			
18. If you are no longer driving, why did you stop?			
19. Are you satisfied with your current vision?			

I have answered the above questions to the best of my knowledge:

_____ _____
Patient's Signature **Date**