OMNI EYE SERVICES

Name: _____

Date of Birth: _____

Eye: _____ Date: _____

Assessment of Visual Function

Please indicate how much difficulty you have seeing things-with your glasses or contracts.

	NA	None	Mild	Mod.	Much
1) Reading . . . . . medicine labels, telephone book, food labels, newspapers, books, maps, etc.	❑	❑	❑	❑	❑
2) Writing checks or filling out forms	❑	❑	❑	❑	❑
3) Doing fine handwork . . . . . sewing, crocheting, carpentry, etc.	❑	❑	❑	❑	❑
4) Cooking or working on the computer	❑	❑	❑	❑	❑
5) Playing table games. . . . . bingo, dominos, card games, etc.	❑	❑	❑	❑	❑
6) Recognizing people in the same room.	❑	❑	❑	❑	❑
7) Seeing TV clearly	❑	❑	❑	❑	❑
8) Seeing obstacles on the ground . . . . . curbs, stairs, pot holes, etc.	❑	❑	❑	❑	❑
9) Taking part in sports . . . . . golf, tennis, bowling,etc.	❑	❑	❑	❑	❑
10) Driving . . . . . day or night, glare, reading signs, etc.	❑	❑	❑	❑	❑
11) Difficulty with other activities	❑	❑	❑	❑	❑

Please list activities**:** _____

_____

By: _____

Patient Signature*:* _____ Date*:* _____