VISUAL SELF ASSESSMENT
(with glasses)

PATIENT NAME: ______________________________ Date______________

1. Please describe your current needs, limitations, and reason for today's visit:

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2. Do you have any difficulty seeing road signs? Yes No

3. Do you have difficulty with night driving due to troubled vision? Yes No

4. Do you have any difficulty with glare or halos from headlights? Yes No

5. Do you have any difficulty with glare or halos from sunlight? Yes No

6. Do you have difficulty driving in inclement weather (rain, snow, dark roads) due to visual blurring? Yes No

7. Do you have any difficulty reading? Yes No

8. Do you have any difficulty with crafts, shop work or other handiwork? Yes No

9. Do you have any difficulty distinguishing colors? Yes No

10. Do you have any difficulties with depth perception? Yes No

11. Do you have difficulties with contrast against a dark background or cloudy skies? Yes No

12. Do you feel that your glasses are changing but are not fully correcting your visual needs? Yes No

13. Do you feel that your visual problems are becoming progressively worse since your last examination? Yes No

14. Does your vision limit you in any other way we should know about?

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Signature: ____