



Patient Name: _____

Date of Birth: _____

Do you have difficulty, even with glasses with the following activities?

1. Reading small print such as labels on medicine bottles, a telephone book or food labels?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Moderate Amount	
	<input type="checkbox"/> A Great Deal	<input type="checkbox"/> Unable to do the activity	
2. Reading a newspaper or book?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Moderate Amount	
	<input type="checkbox"/> A Great Deal	<input type="checkbox"/> Unable to do the activity	
3. Seeing steps, stairs or curbs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Moderate Amount	
	<input type="checkbox"/> A Great Deal	<input type="checkbox"/> Unable to do the activity	
4. Reading traffic signs, street signs or store signs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Moderate Amount	
	<input type="checkbox"/> A Great Deal	<input type="checkbox"/> Unable to do the activity	
5. Doing fine handwork like sewing, knitting, crocheting or carpentry?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Moderate Amount	
	<input type="checkbox"/> A Great Deal	<input type="checkbox"/> Unable to do the activity	
6. Writing checks or filling out forms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Moderate Amount	
	<input type="checkbox"/> A Great Deal	<input type="checkbox"/> Unable to do the activity	
7. Playing games such as bingo, dominos, card games or mahjong?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Moderate Amount	
	<input type="checkbox"/> A Great Deal	<input type="checkbox"/> Unable to do the activity	
8. Watching television?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Moderate Amount	
	<input type="checkbox"/> A Great Deal	<input type="checkbox"/> Unable to do the activity	

Patient Signature _____

Date _____