Columbus Eye Clinic & Laser Surgery Center

Patient Name: _____

PLEASE CIRCLE YOUR RESPONSE ON EACH LINE
(Please leave blank if it does not apply)

Have you been bothered by:		**Answer**		**Comments**
Overall decline in vision	Little	Some	A lot	
Blurry Vision	Little	Some	A lot	
Glare or poor night vision	Little	Some	A lot	
Sensitivity to light	Little	Some	A lot	
Seeing rings or halos around lights	Little	Some	A lot	
Seeing double	Little	Some	A lot	

Have you noticed a decrease in your vision when you:		**Answer**		**Comments**
Drive during daylight hours	Little	Some	A lot	
Drive during nighttime hours	Little	Some	A lot	
See traffic or road signs	Little	Some	A lot	
Read newspapers or telephone books	Little	Some	A lot	
Read labels, price tags or medicine bottles	Little	Some	A lot	
Use a computer	Little	Some	A lot	
Do fine handwork or hobbies	Little	Some	A lot	
Look at colors	Little	Some	A lot	
Sew, cook or work around the house	Little	Some	A lot	
Play cards	Little	Some	A lot	
Watch TV	Little	Some	A lot	
Look at steps or curbs	Little	Some	A lot	
Work at your job	Little	Some	A lot	
Try to recognize people	Little	Some	A lot	
Look out of only one eye	Little	Some	A lot	
Other	Little	Some	A lot	

Patient's Signature: _____Date:_____