# COLUMBUS EYE ASSOCIATES

Patient Name: _____ Chart # _____ Date: _____

Reason for exam today (patient words): _____

_____

_____

_____

## VISUAL FUNCTIONAL STATUS

**Circle Responses**

| | | |
|---|---|---|
| 1. Do you have difficulty seeing street signs or to drive? (curbs, freeway exits, traffic lights, halos/glare around lights). | YES | NO |
| 2. Do you have difficulty seeing TV or movies? (faces, numbers, or printing). | YES | NO |
| 3. Do you have difficulty reading small print with good light, complete blinking and proper glasses? (books, newspaper, telephone book, medicine labels, instructions). | YES | NO |
| 4. Do you have difficulty performing detailed work? (sewing, knitting, crocheting, embroidery, baiting a fish hook or other fine task). | YES | NO |
| 5. Do you have difficulty with personal correspondences? (writing checks, reading bills, filling out forms). | YES | NO |
| 6. Do you have difficulty with leisure activities such as sports or hobbies? (playing card games, bingo, dominoes, or sport activities such as bowling, hunting, golf, tennis, other) | YES | NO |
| 7. Do you have visual difficulty functioning around the house? (cooking, ironing, general household upkeep, climbing steps or curbs, dialing the telephone, telling time on watch, using public transportation) | YES | NO |
| 8. Do you have difficulty recognizing faces of people?(in church, grocery store, clubs, and other daily activities? | YES | NO |
| 9. If you live alone and wish to remain independent, are you unable to care for yourself with your Present vision? | YES | NO |

## VISUAL SYMPTOMS – Do you have any of the following?

| | | | |
|---|---|---|---|
| **1.** | Double or distorted vision? | YES | NO |
| **2.** | Glare, halos, rings around lights? | YES | NO |
| **3.** | Difficulty with color perception? | YES | NO |
| 4. | Difficulty with depth Perception? | YES | NO |
| 5. | Worsening of vision – blurred vision? | YES | NO |

Patient Signature: Date:

*For Office Use Only:*

## MEDICAL NECESSITY FOR CATARACT SURGERY

___ Right Eye ___ Left Eye

What specific improvements in your daily life do you hope to gain with surgery?: _____

_____

_____

Best corrected Snellen VA – Distance: 20/ Near: J Medium BAT if glare symptoms: 20/

20/ J 20/

*With blinking, good light and proper bifocal.*