

Please complete this page **ONLY** if you have been referred to Commonwealth Eye Surgery for a cataract evalutaion or for a YAG laser capsulotomy evaluation.

## FUNCTIONAL VISUAL PROBLEMS

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

REASON FOR EXAM TODAY (in your own words): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Because of your vision, do you have trouble: (please circle response)

Walking down steps or over curbs, etc.? YES NO

Watching television? YES NO

Reading? N/A YES NO

Example: \_\_\_\_\_

Driving? N/A YES NO

With your work? YES NO

Doing hobbies or recreation? YES NO

Example: \_\_\_\_\_

Does glare from headlight prevent you from driving at night? YES NO

Do you have difficulty seeing at night? YES NO

Does your vision worsen in sunlight? YES NO

Do you have difficulty with color preception? YES NO

Do you have difficulty with depth perception? YES NO

Do you live alone? YES NO

\_\_\_\_\_

What specific improvements in your daily life do you hope to gain? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PATIENT'S SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_