Oregon
Eye Specialists, P.C.

VISION QUALITY QUESTIONNAIRE

Name: ________________________________ DOB: ____________________

Symptoms – Have you been bothered by:

Poor night vision?	☐ YES	☐ NO
Seeing rings or halos around lights?	☐ YES	☐ NO
Glare caused by headlights or bright sun?	☐ YES	☐ NO
Hazy and/or blurry vision?	☐ YES	☐ NO
Unable to see well in poor or dim light?	☐ YES	☐ NO
Poor color vision?	☐ YES	☐ NO
Double vision?	☐ YES	☐ NO

Visual Functions – Do you have ANY difficulty, even with glasses, performing the following activities?

Reading small print such as medication labels or the phone book?	☐ YES	☐ NO	☐ N/A
Reading the newspaper, a book, or a recipe?	☐ YES	☐ NO	☐ N/A
Using a cell phone or iPad/tablet?	☐ YES	☐ NO	☐ N/A
Using the computer?	☐ YES	☐ NO	☐ N/A
Recognizing people when they are close to you?	☐ YES	☐ NO	☐ N/A
Seeing steps or curbs?	☐ YES	☐ NO	☐ N/A
Reading traffic, street, or store signs?	☐ YES	☐ NO	☐ N/A
Doing hobbies like sewing, playing cards, carpentry, tying flies?	☐ YES	☐ NO	☐ N/A
Writing checks or filling out forms?	☐ YES	☐ NO	☐ N/A
Playing sports like bowling, tennis, or golf?	☐ YES	☐ NO	☐ N/A
Watching television?	☐ YES	☐ NO	☐ N/A

Continued on the reverse →

Driving:

Do you currently drive a car?	☐ YES ☐ NO
If you have stopped driving, when did you last drive? ☐ Less than 6 months ago ☐ 6-12 months ago ☐ More than 1 year ago	
How much difficulty do you have driving during the day because of your vision? ☐ None ☐ A little ☐ Moderate ☐ A great deal	
How much difficulty do you have driving at night because of your vision? ☐ None ☐ A little ☐ Moderate ☐ A great deal	

X____
Patient Signature *(or person authorized to sign for patient)*

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Date

FOR PHYSICIAN USE ONLY
Eye being evaluated: ☐ RIGHT ☐ LEFT
Procedure being considered: ☐ CE/IOL ☐ YAG laser capsulotomy

Improving VISION. Improving LIFE.