Callahan Eye Clinic, PC

Functional Impairment Due to Reduced Visual Acuity

Patient Name: ______________________________ Date: _______________

Patient Signature: ___________________________

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1. Has your vision reached a point that some daily activities are harder to accomplish? YES NO (Circle one.)

If YES - I'm having a problem with (check all that apply):

- ☐ Using Computer, Cell Phone and/or iPad
- ☐ Writing Checks or Forms
- ☐ Judging Steps or Curbs
- ☐ Driving and Parking
- ☐ Seeing Traffic Lights
- ☐ Reading Road Signs
- ☐ Glare, Halos, or Rings Around Lights
- ☐ Seeing familiar faces across room or place of worship.
- ☐ Reading my medicine bottles.

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2. Has your vision reached a point that you don't enjoy hobbies or sports like you used to? YES NO (Circle one.)

If YES - I'm having a problem with (check all that apply):

- ☐ Sewing or Cross-stitch (Seeing thread; colors)
- ☐ Watching TV
- ☐ Reading Music
- ☐ Crossword Puzzles
- ☐ Cooking
- ☐ Fishing or Hunting
- ☐ Golf or Tennis
- ☐ Reading (Bible, Books, Magazines, Newspaper, Phone Book)