PATIENT QUESTIONNAIRE

PATIENT NAME: ____

To prepare for your appointment, please answer the following questions:

1. Please think about different vision tasks that you find difficult and list them below. You might wish to treat this like a diary and whenever you have a problem, then write it down. Take a minute to think about where these tasks take place and what type of lighting is available in that location. The day before your appointment, please prioritize the tasks below in order of their importance.

VISION TASK	LOCATION/ROOM	LIGHTING
Reading the newspaper	kitchen	Overhead light 2-60watt bulbs

2. Does sunlight bother your eyes? YES NO
If you wear sunglasses, please bring them.

3. Do you wear eyeglasses? YES NO
If yes, please bring them for your appointment.

4. Are you using any magnifying vision aids? YES NO
If yes, please bring them for your appointment.

PLEASE BRING THIS QUESTIONNAIRE WITH YOU TO THE APPOINTMENT