Hodges Eye Care and Surgical Center
The view from here is always clear.

PATIENT'S NAME_____DATE_____

To give us a better idea of how to help improve your visual problem(s), please provide us with the following information. As with all of your medical records, this form is considered confidential.

Does your sight make it a problem for you to:

	CIRCLE ONE
Read the newspapers…….	YES NO
Read a telephone book…….	YES NO
See traffic signs……..	YES NO
Read labels at the grocery store……..	YES NO
Recognize people…….. …….	YES NO
Work on a computer…….	YES NO
Watch Television…….	YES NO
Work at your job……..	YES NO
Manage your home……	YES NO
See golf balls…….	YES NO
Play tennis…….	YES NO
Other…….	YES NO

Have you been bothered by:

Poor night vision……..	YES NO
Seeing rings around lights……	YES NO
Glare……..	YES NO

Do you have difficulty driving at night?	YES NO
Do you have difficulty driving during the day?	YES NO

_____
Patient's Signature