

NAME _____ DATE _____

**DO YOU HAVE ANY OF THESE COMPLAINTS? (WITH OR WITHOUT
YOUR GLASSES ON)**

BLURRED VISION _____

OVERALL DECLINE IN VISION _____

GLARE, SENSITIVITY TO LIGHT _____

POOR NIGHT VISION _____

HALOS AROUND LIGHTS _____

LOSS OF DEPTH PERCEPTION _____

DOUBLE VISION _____

DIFFICULTY DRIVING AT NIGHT _____

READING TRAFFIC SIGNS _____

READING SMALL PRINT _____

PLAYING SPORTS (GOLF, TENNIS) _____

PATIENTS SIGNATURE _____ **DATE** _____