Low Vision Questionnaire

Circle Yes or No for each question below. Please answer the question in terms of how you see when wearing your current lens prescription.

NAME _____ DATE_____

Do you ever feel that problems with your vision make it difficult for you to do the things you would like to do?	1 - Yes	0 - No
Can you see the large print headlines in the newspaper?	0 - Yes	1 - No
Can you see the regular print in newspapers, magazines or books?	0 - Yes	1 - No
Can you see numbers and words in small print, such as a in telephone book or on a menu?	0 - Yes	1 - No
When you are waling in the street, can you see the WALK sign and street names?	0 - Yes	1 - No
When crossing the street or in a vehicle, do cars seem to appear very suddenly?	1 - Yes	0 - No
Does trouble with your vision make it difficult to watch TV, see your phone, play cards, do sewing, or any similar type of activity?	1 - Yes	0 - No
Does trouble with your vision make it difficult to see labels on medicine bottles?	1 - Yes	0 - No
Does trouble with your vision make it difficult for you to read prices when you shop?	1 - Yes	0 - No
Does trouble with your vision make it difficult for you to read your mail?	1 - Yes	0 - No
Does trouble with your vision make it difficult for you to read your own handwriting?	1 - Yes	0 - No
Can you recognize faces of family or friends when you are across from them in an average size room?	0 - Yes	1 - No
Do you have any difficulty seeing in dim light?	1 - Yes	0 - No
Do you tend to sit very close to the television or computer screen?	1 - Yes	0 - 1No
Total score for both columns		

A total score of eight or more suggests the need for a low vision evaluation.

kc vision performance

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