Patient Name: _____ MEC: _____ Date: _____

VF-14 QOL Questionnaire

Please fill this form out and bring it with you when you come in for your examination.

CONTACT LENS WEARERS: If you wear contact lenses, you have the choice to continue wearing them, including to your appointment, but please bring your glasses. You can also stop wearing your contact lenses for the 2 weeks prior to your appointment. This will allow us to take measurements of your eye at the time of your consultation. If you decide to keep wearing the contact lenses, and you are a candidate for surgery, you will be scheduled to return for the measurements later, when you have stopped wearing your contact lenses for 2 weeks.

Because of your vision, how much difficulty do you have with the following activities?
Check the box that best describes how much difficulty you have, even with glasses.
If you do not perform the activity for reasons unrelated to your vision, circle "n/a"

Activity		None	A little	Moderate	Great deal	Unable to do
1. Reading small print, such as medicine bottle labels, a telephone book, or food labels	n/a	☐	☐	☐	☐	☐
2. Reading a newspaper or a book	n/a	☐	☐	☐	☐	☐
3. Reading a large-print book or large-print newspaper or numbers on a telephone	n/a	☐	☐	☐	☐	☐
4. Recognizing people when they are close to you	n/a	☐	☐	☐	☐	☐
5. Seeing steps, stairs or curbs	n/a	☐	☐	☐	☐	☐
6. Reading traffic signs, street signs or store signs	n/a	☐	☐	☐	☐	☐
7. Doing fine handwork like sewing, knitting, crocheting, carpentry	n/a	☐	☐	☐	☐	☐
8. Writing checks or filling out forms	n/a	☐	☐	☐	☐	☐
9. Playing games such as bingo, dominos, card games, or mahjong	n/a	☐	☐	☐	☐	☐
10. Taking part in sports like bowling, handball, tennis, golf	n/a	☐	☐	☐	☐	☐
11. Cooking	n/a	☐	☐	☐	☐	☐
12. Watching television	n/a	☐	☐	☐	☐	☐
13. Driving during the day	n/a	☐	☐	☐	☐	☐
14. Driving at night	n/a	☐	☐	☐	☐	☐

Patient Signature: _____