PROFFITT EYE CENTER

Visual Inventory Sheet

Patient Name ________________________ **Chart Number** ____________

Please check YES or NO to the following questions:

Due to decreased vision, do you have difficulty with

	YES	NO
1. Reading small print, such as medicine bottles or a telephone directory?	☐	☐
2. Reading a newspaper or a book?	☐	☐
3. Reading a large print book or large print newspaper, or numbers on a telephone?	☐	☐
4. Recognizing people when they are close to you?	☐	☐
5. Seeing steps, stairs or curbs?	☐	☐
6. Reading traffic and/or street signs or store signs?	☐	☐
7. Doing fine handwork such as sewing, knitting, crocheting or carpentry?	☐	☐
8. Writing checks or filling out forms?	☐	☐
9. Playing games such as Bingo, dominos, cards?	☐	☐
10. Participating in sports such as bowling, tennis or golf, due to decreased vision or glare?	☐	☐
11. Cooking or reading cookbooks or recipes?	☐	☐
12. Viewing television and seeing news bulletins (news crawlers) or sports scores on the screen?	☐	☐
13. With daytime driving due to decreased vision or glare?	☐	☐
14. With night driving due to decreased vision or glare from car lights?	☐	☐

Do you feel your vision difficulties are to the point that you wish to consider cataract surgery? ☐ **Yes** ☐**No**

Patient signature **X** ________________________ Date ____________

Reviewed by: ________________________ Date ____________