<u>CAN YOU SEE?</u>

To help us understand your visual problems, please circle the appropriate response:

1.) Does your vision seem cloudy and blurry? (Yes / No)

2.) Does glare from the sun make you eyes blur? (Yes / No)

3.) Does glare from on-coming car lights bother you? (Yes / No)

4.) Does blurred vision interfere with your driving ability? (Yes / No)

5.) Do you avoid driving at night? (Yes / No)

6.) Did you have trouble passing the vision test at you last driver's license exam? (Yes / No)

7.) Do your friend or family seem to think your vision is failing? (Yes / No)

8.) Do you have difficulty reading the newspaper? (Yes / No)

9.) Do you avoid reading because of poor vision or eye-strain? (Yes / No)

10.) Do you have difficulty reading the fine print on medicine bottles? (Yes / No)

11.) Do your eyes strain and ache because they don't see well? (Yes / No)

12.) Do you use a magnifier to try to see better? (Yes / No)

13.) Does blurred vision make it difficult for you to walk up a stairway? (Yes / No)

14.) Are you afraid you may stumble and fall because you can't see well? (Yes/No)

15.) Are you uncomfortable in unfamiliar surroundings because you can't see well? (Yes / No)

16.) Are you slow to recognize people because you don't see well? (Yes / No)

17.) Do you sometimes take your glasses off to try to see better? (Yes / No)

18.) Have you been told new glasses won't help? (Yes / No)

19.) Have you tried new glasses but they did not help? Yes / No)

20.) Is there anything else you would like to tell us about how your vision fails you?

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Signed_____________________________________Date_________________