PATIENT PERSONAL HEALTH HISTORY

(complete form in ink only)

Today's Date:_____

Name:_____ Sex: M F Date of Birth:_____ Age:_____

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

How much are you hindered, limited or disabled by glare (dazzling light) in each of the following activities? (Circle one in each row)

	Never	Sometimes	Frequently
a. Your normal daily activities	0	1	2
b. Driving towards the sun or oncoming headlights	0	1	2
c. Walking outside on a sunny day	0	1	2

Patient Signature: _____