Levenson eye associates

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ACTIVITIES OF DAILY LIFE QUESTIONNAIRE

Patient Name (please print): _____ Date: _____

Dear Patient,
To help us understand any vision problems that you may be experiencing, please answer the following questions. Just check the appropriate response. Your responses will be strictly confidential. Thank you.

YES	NO	
○	○	I sometimes have trouble with glare.
○	○	I sometimes see rings around lights.
○	○	I have trouble driving at night.
○	○	I have given up driving at night.
○	○	I have difficulty reading traffic or street signs.
○	○	I have difficulty reading labels in the grocery store.
○	○	I have difficulty reading books, newspapers, or my mail.
○	○	I have difficulty seeing steps.
○	○	I have difficulty seeing in dim light.
○	○	I sometimes have difficulty recognizing people.
○	○	I sometimes think my vision is blurry or that my glasses need cleaning.
○	○	I think problems with my vision prevent me from doing some things I'd like to do (sewing, golf, tennis, playing cards, etc.)

The main problem I would like to discuss with the doctor today is:

Patient / Parent or Guardian Signature

Date

Riverside Park Place
51 Oak Street
Suite 200
Jacksonville, FL 32204

Mandarin
3020 Hartley Road
Suite 190
Jacksonville, FL 32257

Orange Park
905 Park Avenue
Suite 104
Orange Park, FL 32073

Ponte Vedra Beach
120 A1A North
Suite 102
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Knauer Building
2535 Riverside Avenue
Jacksonville, FL 32204