VISUAL FUNCTION INDEX (VF-14) QUESTIONNAIRE

- **Because of your vison**, how much difficulty do you have with the following activities?
- Check the box that best describes how much difficulty you have, **in one eye or both, even with glasses**.
- If you do not perform the activity for reasons unrelated to your vision, check N/A.

Activity	4 None	3 A Little	2 Moderate	1 Great Deal	0 Unable	N/A
1. Reading small print, such as medicine bottle labels, telephone book, or food labels?	☐	☐	☐	☐	☐	☐
2. Reading a newspaper or book?	☐	☐	☐	☐	☐	☐
3. Reading a large-print book or large-print newspaper or numbers on a telephone?	☐	☐	☐	☐	☐	☐
4. Recognizing people at a close distance?	☐	☐	☐	☐	☐	☐
5. Seeing steps, stairs, or curbs?	☐	☐	☐	☐	☐	☐
6. Reading traffic / street signs / store signs?	☐	☐	☐	☐	☐	☐
7. Doing fine handiwork like sewing, knitting, crocheting, carpentry, etc.?	☐	☐	☐	☐	☐	☐
8. Writing checks or filling out forms?	☐	☐	☐	☐	☐	☐
9. Playing games such as bingo, dominoes, card games, or mahjong?	☐	☐	☐	☐	☐	☐
10. Taking part in sports like bowling, handball, tennis, golf, etc.?	☐	☐	☐	☐	☐	☐
11. Cooking?	☐	☐	☐	☐	☐	☐
12. Watching Television?	☐	☐	☐	☐	☐	☐

Do you currently drive a car?	☐ Yes	☐ No		
How much difficulty do you have driving during the day because of your vision?	4 ☐ None	3 ☐ A Little	2 ☐ Moderate	1 ☐ A Great Deal
How much difficulty do you have driving at night because of your vision?	4 ☐ None	3 ☐ A Little	2 ☐ Moderate	1 ☐ A Great Deal
Have you previously driven a car, but since stopped?	☐ Yes	☐ No		
IF YES, when did you stop driving?	☐ Less than 6 months ago	☐ 6 to 12 months ago	☐ More than 12 months ago	
IF YES, why did you stop driving?	☐ Poor Vision	☐ Other Illness	☐ Other Reason	

Patient Name: _____ **DOB**: _____

Patient Signature: _____ **Date**: _____

Doctor Signature: _____ **Date**: _____

PLEASE MAIL THIS FORM BACK BEFORE YOUR APPOINTMENT