Dr. Shaleen Belani
21135 Whitfield Place, Unit #10 Potomac Falls, VA 20165

Name: _____ **DOB:** _____

Eye Being Evaluated: **Right** ☐ **Left** ☐

Visual Functioning

Do you have difficulty with the following activities (with glasses):	Yes	No	Don't Do
Reading small print, such as medicine bottles or telephone books			
Reading a newspaper or book			
Reading a large print book or other large print			
Recognizing people when they are close to you			
Seeing steps, stairs or curbs			
Reading traffic signs, street signs, or store signs			
Doing fine handwork like sewing, knitting, carpentry or models			
Writing checks or filling out forms			
Playing games such as bingo, dominos or card games			
Participating in sports like bowling, tennis or golf			
Watching television			
Cooking			

Symptoms

Have you been bothered by:	Yes	No
Poor night vision		
Seeing rings or halos around lights		
Glare caused by headlights or bright sunlight		
Hazy and/or blurred vision		
Seeing well in poor or dim light		
Poor color vision		
Double vision from one eye		

Driving

Have you ever driven a car? Yes ☐ No ☐

How much difficulty do you have driving during the day because of your vision?

No difficulty ☐ Little difficulty ☐
Moderate ☐ Severe ☐

Have you given up driving during the day due to your vision Yes ☐ No ☐

How much difficulty do you have driving at night because of your vision?

No difficulty ☐ Little difficulty ☐
Moderate ☐ Severe ☐

Have you given up driving at night due to your vision Yes ☐ No ☐

_____ _____

Signature Date