Visual Functioning Questionnaire - 25

Purpose: To record information on the quality of the patient's vision.
When: Baseline and visits every 6 months thereafter including via telephone interview for missed visits.
By whom: Clinic coordinator or self-administered by the patient.
Instructions: Clinic coordinator completes section A on page 1 of this form; the patient completes Section C. The clinic coordinator should review the completed form for missing responses and resolve any problems before the patient leaves the clinic. Section B on page 1 should then be completed by clinic coordinator and reattached to the questionnaire.

A. Clinic, visit, and patient identification

1. Clinic ID code: ___ ___ ___ ___

2. Patient ID#: ___ ___ ___ ___

3. Patient name code: ___ ___ ___ ___ ___

4. Date of visit *(date patient completed the form)*:

___ ___ - ___ ___ ___ - ___ ___
day month year

5. Visit ID code: ___ ___ ___

B. Administrative information

(To be completed by clinic staff after survey is completed.)

6. How was the questionnaire completed *(check only one):*

Self-administered by patient	(1)
In-person interview	(2)
Telephone interview	(3)
Other *(specify)*:	(4)

_____

_____

7. VQ form used *(check only one):*

Standard print	(1)
Large print	(2)

8. What was the quality of this interview *(check only one):*

Good	(1)
Fair	(2)
Poor (explain):	(3)

_____

_____

Not applicable	(N)

9. Date form reviewed:

___ ___ - ___ ___ ___ - ___ ___
day month year

10. Clinic Coordinator PIN: ___ ___

11. Clinic Coordinator signature:

_____

C. Visual Functioning Questionnaire

Please choose the response that best describes your situation.
Please answer all the questions as if you were wearing your glasses or contact lenses (if any).
Please take as much time as you need to answer each question. All your answers are confidential. In order for this survey to improve our knowledge about vision problems and how they affect your quality of life, your answers must be as accurate as possible. Remember, if you wear glasses or contact lenses for a particular activity, please answer all of the following questions as though you were wearing them.

PART 1 - GENERAL HEALTH AND VISION

12. At the present time, would you say your eyesight using both eyes (with glasses or contact lenses, if you wear them) is **excellent**, **good**, **fair**, **poor**, or **very poor** or are you **completely blind** *(circle one)*:

Excellent	Good	Fair	Poor	Very poor	Completely blind
1	2	3	4	5	6

13. How much of the time do you **worry** about your eyesight *(circle one)*:

None of the time	A little of the time	Some of the time	Most of the time	All of the time
1	2	3	4	5

14. How much **pain or discomfort** have you had **in and around your eyes** (for example, burning, itching or aching)? Would you say it is *(circle one)*:

None	Mild	Moderate	Severe	Very severe
1	2	3	4	5

PART 2 - DIFFICULTY WITH ACTIVITIES

The next questions are about how much difficulty, if any, you have doing certain activities wearing your glasses or contact lenses, if you use them for that activity. (circle one answer for each item)

	No difficulty at all	A little difficulty	Moderate difficulty	Extreme difficulty	Stopped doing this because of your eyesight	Stopped doing this for other reasons or not interested in doing this
15. How much difficulty do you have **reading ordinary print in newspapers**?	1	2	3	4	5	6
16. How much difficulty do you have doing work or hobbies that require you to **see well up close**, such as cooking, sewing, fixing things around the house, or using hand tools?	1	2	3	4	5	6
17. Because of your eyesight, how much difficulty do you have **finding something on a crowded shelf**?	1	2	3	4	5	6
18. How much difficulty do you have **reading street signs or the names of stores**?	1	2	3	4	5	6
19. Because of your eyesight, how much difficulty do you have **going down steps, stairs, or curbs in dim light or at night**?	1	2	3	4	5	6

	No difficulty at all	A little difficulty	Moderate difficulty	Extreme difficulty	Stopped doing this because of your eyesight	Stopped doing this for other reasons or not interested in doing this
20. Because of your eyesight, how much difficulty do you have **noticing objects off to the side while you are walking along**?	1	2	3	4	5	6
21. Because of your eyesight, how much difficulty do you have **seeing how people react to things** you say?	1	2	3	4	5	6
22. Because of your eyesight, how much difficulty do you have **picking out and matching your own clothes**?	1	2	3	4	5	6
23. Because of your eyesight, how much difficulty do you have **visiting with people in their homes, at parties, or in restaurants**?	1	2	3	4	5	6
24. Because of your eyesight, how much difficulty do you have **going out to see movies, plays, or sports events**?	1	2	3	4	5	6

25. Are you **currently driving**, at least once in a while *(circle one)*:

Yes	No
1	2

If Yes, skip to item 25c.

25a. If No, have you **never** driven a car or have you **given up driving** *(circle one)*:

Never drove	Gave up
1	2

If never drove, skip to item 28.

25b. IF GAVE UP DRIVING: Was that **mainly because of your eyesight, mainly for some other reason**, or because of **both your eyesight and other reasons**? *(circle one)*:

Mainly eyesight	Mainly other reasons	Both eyesight and other reasons
1	2	3

Skip to item 28.

25c. IF CURRENTLY DRIVING: How much difficulty do you have **driving during the daytime in familiar places**? Would you say you have *(circle one)*:

No difficulty at all	A little difficulty	Moderate difficulty	Extreme difficulty
1	2	3	4

*For each of the following statements, please tell me if you have **no difficulty at all**, **a little difficulty**, **moderate difficulty**, **extreme difficulty**, you **stopped doing this because of your eyesight**, or you **stopped doing this for other reasons or are not interested in doing this**.*

	No difficulty at all	A little difficulty	Moderate difficulty	Extreme difficulty	Stopped doing this because of your eyesight	Stopped doing this for other reasons or not interested in doing this
26. How much difficulty do you have **driving at night**?	1	2	3	4	5	6
27. How much difficulty do you have **driving in difficult conditions, such as in bad weather, during rush hour, on the freeway, or in the city traffic**?	1	2	3	4	5	6

PART 3 - RESPONSES TO VISION PROBLEMS

*The next questions are about how things you do may be affected by your vision. For each one, I'd like you to tell me if this is true for **all**, **most**, **some, a little**, or **none** of the time. (circle one answer for each item)*

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
28. Do you accomplish less than you would like because of your vision?	1	2	3	4	5
29. Are you limited in how long you can work or do other activities because of your vision?	1	2	3	4	5
30. How much does pain or discomfort **in or around your eyes,** for example, burning, itching or aching, keep you from doing what you'd like to be doing?	1	2	3	4	5

*For each of the following statements, please tell me if it is **definitely true**, **mostly true**, **mostly false**, or **definitely false** for you or you are **not sure**. (circle one answer for each item)*

	Definitely true	Mostly true	Not sure	Mostly false	Definitely false
31. I stay home most of the time because of my eyesight:	1	2	3	4	5
32. I feel **frustrated** a lot of the time because of my eyesight:	1	2	3	4	5
33. I have **much less control** over what I do, because of my eyesight:	1	2	3	4	5
34. Because of my eyesight, I have to **rely too much on what other people tell me**:	1	2	3	4	5
35. I need a lot of help from others because of my eyesight:	1	2	3	4	5
36. I worry about **doing things that will embarrass myself or others**, because of my eyesight:	1	2	3	4	5

This questionnaire is now complete. Thank you!