

# Assessing Functional Vision

Eye conditions					
Glasses	Yes	No	Bifocals	Multifocals	Reading
Walking Aid	Yes	No	Specify:		
<b>Summary of functional vision difficulties</b> (complete after questions answered)					

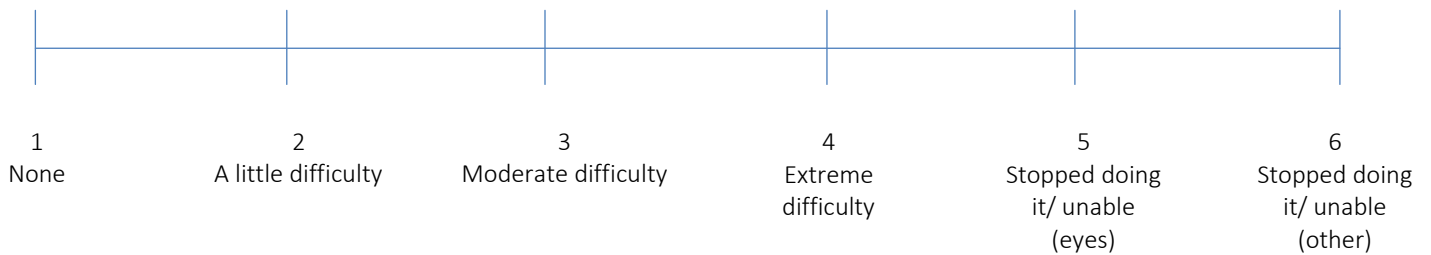
1. What **vision conditions** have been diagnosed by your doctor? (check same as above)

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2. Do you have any difficulty **getting around** INSIDE or OUTSIDE because of your eyesight?

Yes	No	Please comment:	
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3. Is it difficult to tell where the **edge of the step** is?



4. Have you ever **missed the edge** of a step?

Yes	No	Please comment on why this happened	
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5. Do you have any difficulty going **up or down steps and/ or gutters in the day time**?

Yes	No	Please comment on difficulties	
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6. Do you have any difficulty going **up or down steps and/ or gutters in dim light or at night??**

Yes	No	Please comment on difficulties	
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7. Do you do anything to **make it safer** when going up and down gutters? Please comment.

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