Visual Function (VF-14) Questionnaire

Patient Name: _____ DOB: _____

Please rate any difficulties you have with the following tasks due to your vision, even with glasses.

Activity	**No Difficulty**	**Moderate**	**Severe**
1. Driving during the day	☐	☐	☐
2. Difficulty seeing road signs	☐	☐	☐
3. Participating in sports such as golf, pickleball, tennis, bowling, etc.	☐	☐	☐
4. Watching television	☐	☐	☐
5. Reading a book or newspaper	☐	☐	☐
6. Reading fine print such as food labels, medicine bottles, phone numbers	☐	☐	☐
7. Cooking	☐	☐	☐
8. Sewing, knitting, woodworking	☐	☐	☐
9. Seeing steps or curbs	☐	☐	☐
10. Recognizing faces when close	☐	☐	☐
11. Writing checks or completing forms	☐	☐	☐
12. Playing games such as cards, bingo, etc.	☐	☐	☐

Please list activities you perform without glasses: _____

What do you hope to be able to do without glasses after cataract surgery?

Please list: _____

Do you aspire to be as glasses free as possible after cataract surgery?   Yes   No

☐   Yes, I feel my vision is affecting my daily activities; therefore, I am considering cataract surgery.

☐   No, I do not feel my vision has decreased enough to consider cataract surgery at this time.

Patient signature _____ Date _____