Patient Name: _____ DOB: _____ Date of Visit: _____

VF-14 QOL Questionnaire

Because of your vision, how much difficulty do you have with the following activities?
Check the box that best describes how much difficulty you have, even with glasses.
If you do not perform the activity for reasons unrelated to your vision, circle "n/a"

Activity		None	A little	Moderate	Great deal	Unable to do
1. Reading small print, such as medicine bottle labels, a telephone book, or food labels	n/a	☐	☐	☐	☐	☐
2. Reading a newspaper or a book	n/a	☐	☐	☐	☐	☐
3. Reading a large-print book or large-print newspaper or numbers on a telephone	n/a	☐	☐	☐	☐	☐
4. Recognizing people when they are close to you	n/a	☐	☐	☐	☐	☐
5. Seeing steps, stairs or curbs	n/a	☐	☐	☐	☐	☐
6. Reading traffic signs, street signs or store signs	n/a	☐	☐	☐	☐	☐
7. Doing fine handwork like sewing, knitting, crocheting, carpentry	n/a	☐	☐	☐	☐	☐
8. Writing checks or filling out forms	n/a	☐	☐	☐	☐	☐
9. Playing games such as bingo, dominos, card games, or mahjong	n/a	☐	☐	☐	☐	☐
10. Taking part in sports like bowling, handball, tennis, golf	n/a	☐	☐	☐	☐	☐
11. Cooking	n/a	☐	☐	☐	☐	☐
12. Watching television	n/a	☐	☐	☐	☐	☐
13. Driving during the day	n/a	☐	☐	☐	☐	☐
14. Driving at night	n/a	☐	☐	☐	☐	☐

Patient Signature: _____

Office use only:	**(C)** *# checked boxes in column*					
	(F) *factored amounts*	X4 =	X3 =	X2 =	X1 =	**0**

C = total number of **C**hecked boxes in column

F = sum of the **F**actored amounts

Final Score: (F _____ / C _____) x 25 = V

V =Final **V**-14 score

V = ☐

MD Signature: _____