

# National Eye Institute's Visual Functioning Questionnaire

The following is a survey with statements about problems which involve your vision or feelings that you have about your vision condition. After each question 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, please answer all of the following questions as though you were wearing them.

## INSTRUCTIONS:

1. In general we would like to have people try to complete these forms on their own. If you find that you need assistance, please feel free to ask the project staff and they will assist you.
2. Please answer every question - unless you are asked to skip questions because they do not apply to you.
3. Answer the questions by circling the appropriate number.
4. If you are unsure of how to answer a question, please give the best answer you can and make a comment in the left margin.

## STATEMENT OF CONFIDENTIALITY:

All information that would permit identification of any person who completed this questionnaire will be regarded as strictly confidential. Such information will be used only for the purposes of this study and will not be disclosed or released for any other purposes without prior consent, except as required by law.

## PART 1 - GENERAL HEALTH AND VISION

1. In general, would you say your overall health is:

Excellent	1	Fair	4
Very Good	2	Poor	5
Good	3		

2. 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?

<b>Excellent 1</b>	<b>Fair 4</b>
<b>Very Good 2</b>	<b>Poor 5</b>
<b>Good 3</b>	<b>Completely Blind 6</b>

**3. How much of the time do you worry about your eyesight?**

<b>None of the time 1</b>	<b>Most of the time 4</b>
<b>A little of the time 2</b>	<b>All of the time 5</b>
<b>Some of the time 3</b>	

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

<b>None 1</b>	<b>Severe 4</b>
<b>Mild 2</b>	<b>Very severe 5</b>
<b>Moderate 3</b>	

**PART 2 - DIFFICULTY WITH ACTIVITIES**

The next questions are about how much difficulty, you have doing certain activities wearing your glasses or contact lenses if you use them for that activity.

**5. How much difficulty do you have reading ordinary print in newspapers? Would you say you have:**

<b>No difficulty at all 1</b>	<b>Moderate difficulty 3</b>
<b>A little difficulty 2</b>	<b>Extreme difficulty 4</b>
<b>Stopped doing this because of your eyesight 5</b>	
<b>Stopped doing this for other reasons or not interested in doing this 6</b>	

**6. 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? Would you say:**

<b>No difficulty at all 1</b>	<b>Moderate difficulty 3</b>
<b>A little difficulty 2</b>	<b>Extreme difficulty 4</b>
<b>Stopped doing this because of your eyesight 5</b>	
<b>Stopped doing this for other reasons or not interested in doing this 6</b>	

**7. Because of your eyesight, how much difficulty do you have finding something on a crowded shelf?**

<b>No difficulty at all 1</b>	<b>Moderate difficulty 3</b>
<b>A little difficulty 2</b>	<b>Extreme difficulty 4</b>
<b>Stopped doing this because of your eyesight 5</b>	
<b>Stopped doing this for other reasons or not interested in doing this 6</b>	

**8. How much difficulty do you have reading street signs or the names of stores?**

<b>No difficulty at all</b>	<b>1</b>	<b>Moderate difficulty</b>	<b>3</b>
<b>A little difficulty</b>	<b>2</b>	<b>Extreme difficulty</b>	<b>4</b>
<b>Stopped doing this because of your eyesight</b>			
<b>5</b>			
<b>Stopped doing this for other reasons or not interested in doing this</b>			
<b>6</b>			

**9. Because of your eyesight, how much difficulty do you have going down steps, stairs, or curbs in dim light or at night?**

<b>No difficulty at all</b>	<b>1</b>	<b>Moderate difficulty</b>	<b>3</b>
<b>A little difficulty</b>	<b>2</b>	<b>Extreme difficulty</b>	<b>4</b>
<b>Stopped doing this because of your eyesight</b>			
<b>5</b>			
<b>Stopped doing this for other reasons or not interested in doing this</b>			
<b>6</b>			

**10. Because of your eyesight, how much difficulty do you have noticing objects off to the side while you are walking along?**

<b>No difficulty at all</b>	<b>1</b>	<b>Moderate difficulty</b>	<b>3</b>
<b>A little difficulty</b>	<b>2</b>	<b>Extreme difficulty</b>	<b>4</b>
<b>Stopped doing this because of your eyesight</b>			
<b>5</b>			
<b>Stopped doing this for other reasons or not interested in doing this</b>			
<b>6</b>			

**11. Because of your eyesight, how much difficulty do you have seeing how people react to things you say?**

<b>No difficulty at all</b>	<b>1</b>	<b>Moderate difficulty</b>	<b>3</b>
<b>A little difficulty</b>	<b>2</b>	<b>Extreme difficulty</b>	<b>4</b>
<b>Stopped doing this because of your eyesight</b>			
<b>5</b>			
<b>Stopped doing this for other reasons or not interested in doing this</b>			
<b>6</b>			

**12. Because of your eyesight, how much difficulty do you have picking out and matching your own clothes?**

<b>No difficulty at all</b>	<b>1</b>	<b>Moderate difficulty</b>	<b>3</b>
<b>A little difficulty</b>	<b>2</b>	<b>Extreme difficulty</b>	<b>4</b>
<b>Stopped doing this because of your eyesight</b>			
<b>5</b>			
<b>Stopped doing this for other reasons or not interested in doing this</b>			
<b>6</b>			

**13. Because of your eyesight, how much difficulty do you have visiting with people in their homes, at parties, or in restaurants?**

<b>No difficulty at all</b>	<b>1</b>	<b>Moderate difficulty</b>	<b>3</b>
<b>A little difficulty</b>	<b>2</b>	<b>Extreme difficulty</b>	<b>4</b>
<b>Stopped doing this because of your eyesight</b>			
<b>5</b>			
<b>Stopped doing this for other reasons or not interested in doing this</b>			
<b>6</b>			

**14. Because of your eyesight, how much difficulty do you have going out to see movies, plays, or sports events?**

<b>No difficulty at all</b>	<b>1</b>	<b>Moderate difficulty</b>	<b>3</b>
<b>A little difficulty</b>	<b>2</b>	<b>Extreme difficulty</b>	<b>4</b>
<b>Stopped doing this because of your eyesight</b>			
<b>5</b>			
<b>Stopped doing this for other reasons or not interested in doing this</b>			
<b>6</b>			

**15. Are you currently driving, at least once in a while?**

<b>Yes</b>	<b>1</b>	<i>Skip To Q 15c</i>	<b>No</b>	<b>2</b>
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**15a. IF NO: Have you never driven a car or have you given up driving?**

<b>Never drove</b>	<b>1</b>	<i>Skip To Part 3, Q 17</i>	<b>Gave up</b>	<b>2</b>
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**15b. IF YOU GAVE UP DRIVING: Was that mainly because of your eyesight, mainly for some other reason, or because of both your eyesight and other reasons?**

<b>Mainly eyesight</b>	<b>1</b>	<i>Skip To Part 3, Q 17</i>
<b>Mainly other reasons</b>	<b>2</b>	<i>Skip To Part 3, Q 17</i>
<b>Both eyesight and other reasons</b>	<b>3</b>	<i>Skip To Part 3, Q 17</i>

**15c. IF CURRENTLY DRIVING: How much difficulty do you have driving during the daytime in familiar places? Would you say you have:**

<b>No difficulty at all</b>	<b>1</b>	<b>Moderate difficulty</b>	<b>3</b>
<b>A little difficulty</b>	<b>2</b>	<b>Extreme difficulty</b>	<b>4</b>

**16. How much difficulty do you have driving at night? Would you say you have:**

<b>No difficulty at all</b>	<b>1</b>	<b>Moderate difficulty</b>	<b>3</b>
<b>A little difficulty</b>	<b>2</b>	<b>Extreme difficulty</b>	<b>4</b>
<b>Stopped doing this because of your eyesight</b>			
<b>5</b>			
<b>Stopped doing this for other reasons or not interested in doing this</b>			
<b>6</b>			

**16A. How much difficulty do you have driving in difficult conditions, such as in bad weather, during rush hour, on the freeway, or in city traffic? Would you say you have:**

<b>No difficulty at all</b>	<b>1</b>	<b>Moderate difficulty</b>	<b>3</b>
<b>A little difficulty</b>	<b>2</b>	<b>Extreme difficulty</b>	<b>4</b>
<b>Stopped doing this because of your eyesight</b>			
<b>5</b>			
<b>Stopped doing this for other reasons or not interested in doing this</b>			
<b>6</b>			

## **PART 3: RESPONSES TO VISION PROBLEMS**

**17. Do you accomplish less than you would like because of your vision?**

<b>All of the time 1</b>	<b>A little of the time 4</b>
<b>Most of the time 2</b>	<b>None of the time 5</b>
<b>Some of the time 3</b>	

**18. Are you limited in how long you can work or do other activities because of your vision?**

<b>All of the time 1</b>	<b>A little of the time 4</b>
<b>Most of the time 2</b>	<b>None of the time 5</b>
<b>Some of the time 3</b>	

**19. 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? Would you say:**

<b>All of the time 1</b>	<b>A little of the time 4</b>
<b>Most of the time 2</b>	<b>None of the time 5</b>
<b>Some of the time 3</b>	

**For each of the following statements, please circle the number to indicate whether for you the statement is definitely true, mostly true, mostly false, or definitely false for you or you are not sure.**

	<b>Definitely True</b>	<b>Mostly True</b>	<b>Not Sure</b>	<b>Mostly False</b>	<b>Definitely False</b>
<b>20. I stay home most of the time because of my eyesight.</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>21. I feel frustrated a lot of the time because of my eyesight.</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>22. I have much less control over what I do, because of my eyesight.</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>23. Because of my eyesight, I have to rely too much on what other people tell me.</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>24. I need a lot of help from others because of my eyesight.</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>25. I worry about doing things that will embarrass myself or others, because of my eyesight.</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>

## GENERAL HEALTH

**A1. How would you rate your overall health, on a scale where zero is as bad as death and 10 is best possible health?**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>Worst</b>					<b>Best</b>					

## GENERAL VISION

**A2. How would you rate your eyesight now (with glasses or contact lens on, if you wear them), on a scale of from 0 to 10, where zero means the worst possible eyesight, as bad or worse than being blind, and 10 means the best possible eyesight?**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>Worst</b>					<b>Best</b>					

## SUBSCALE: NEAR VISION

**A3. Wearing glasses, how much difficulty do you have reading the small print in a telephone book, on a medicine bottle, or on legal forms? Would you say:**

<b>No difficulty at all</b>	<b>1</b>	<b>Moderate difficulty</b>	<b>3</b>
<b>A little difficulty</b>	<b>2</b>	<b>Extreme difficulty</b>	<b>4</b>
<b>Stopped doing this because of your eyesight</b>		<b>5</b>	
<b>Stopped doing this for other reasons or not interested in doing this</b>		<b>6</b>	

**A4. Because of your eyesight, how much difficulty do you have figuring out whether bills you receive are accurate?**

<b>No difficulty at all</b>	<b>1</b>	<b>Moderate difficulty</b>	<b>3</b>
<b>A little difficulty</b>	<b>2</b>	<b>Extreme difficulty</b>	<b>4</b>
<b>Stopped doing this because of your eyesight</b>		<b>5</b>	
<b>Stopped doing this for other reasons or not interested in doing this</b>		<b>6</b>	

**A5. Because of your eyesight, how much difficulty do you have doing things like shaving, styling your hair, or putting on makeup?**

<b>No difficulty at all</b>	<b>1</b>	<b>Moderate difficulty</b>	<b>3</b>
<b>A little difficulty</b>	<b>2</b>	<b>Extreme difficulty</b>	<b>4</b>
<b>Stopped doing this because of your eyesight</b>		<b>5</b>	
<b>Stopped doing this for other reasons or not interested in doing this</b>		<b>6</b>	

## SUBSCALE: DISTANCE VISION

**A6. Because of your eyesight, how much difficulty do you have recognizing people you know from across a room?**

<b>No difficulty at all</b>	<b>1</b>	<b>Moderate difficulty</b>	<b>3</b>
<b>A little difficulty</b>	<b>2</b>	<b>Extreme difficulty</b>	<b>4</b>
<b>Stopped doing this because of your eyesight</b>			
<b>5</b>			
<b>Stopped doing this for other reasons or not interested in doing this</b>			
<b>6</b>			

**A7. Because of your eyesight, how much difficulty do you have taking part in active sports or other outdoor activities that you enjoy (like golf, bowling, jogging, or walking)?**

<b>No difficulty at all</b>	<b>1</b>	<b>Moderate difficulty</b>	<b>3</b>
<b>A little difficulty</b>	<b>2</b>	<b>Extreme difficulty</b>	<b>4</b>
<b>Stopped doing this because of your eyesight</b>			
<b>5</b>			
<b>Stopped doing this for other reasons or not interested in doing this</b>			
<b>6</b>			

**A8. Because of your eyesight, how much difficulty do you have seeing and enjoying programs on TV?**

<b>No difficulty at all</b>	<b>1</b>	<b>Moderate difficulty</b>	<b>3</b>
<b>A little difficulty</b>	<b>2</b>	<b>Extreme difficulty</b>	<b>4</b>
<b>Stopped doing this because of your eyesight</b>			
<b>5</b>			
<b>Stopped doing this for other reasons or not interested in doing this</b>			
<b>6</b>			

## SUBSCALE: SOCIAL FUNCTION

**A9. Because of your eyesight, how much difficulty do you have entertaining friends and family in your home?**

<b>No difficulty at all</b>	<b>1</b>	<b>Moderate difficulty</b>	<b>3</b>
<b>A little difficulty</b>	<b>2</b>	<b>Extreme difficulty</b>	<b>4</b>
<b>Stopped doing this because of your eyesight</b>			
<b>5</b>			
<b>Stopped doing this for other reasons or not interested in doing this</b>			
<b>6</b>			

## ROLE LIMITATIONS

**A11. The next questions are about things you may do because of your vision. For each item, please circle the number to indicate whether for you this is true for you all, most, some, a little, or none of the time.**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
<b>a. Do you have more help from others because of your vision?</b>	1	2	3	4	5
<b>b. Are you limited in the kinds of things you can do because of your vision?</b>	1	2	3	4	5

## WELL-BEING/DISTRESS and DEPENDENCY

**The next questions are about how you deal with your vision. For each statement, please circle the number to indicate whether for you it is definitely true, mostly true, mostly false, or definitely false for you or you don't know.**

	Definitely True	Mostly True	Not Sure	Mostly False	Definitely False
<b>A12. I am often irritable because of my eyesight.</b>	1	2	3	4	5
<b>A13. I don't go out of my home alone, because of my eyesight.</b>	1	2	3	4	5

**Patient's name:** \_\_\_\_\_

**Date** \_\_\_\_\_