IDAHO EYE and LASER CENTER

LIFESTYLE COMPLAINTS TO ESTABLISH MEDICAL NECESSITY

Do you wear prescription glasses? ☐ *Contacts?* ☐ *Reading glasses only?* ☐

These questions apply to your vision while wearing your glasses or contacts if applicable.

**** IF YOU ARE HAVING SURGERY, THESE QUESTIONS APPLY ONLY TO <u>YOUR SURGICAL EYE</u>****

☐ **LEFT EYE** ☐ **RIGHT EYE**

YES	NO	
☐	☐	1. Glare from bright lights, headlights, and / or sunlight make it difficult to drive.
☐	☐	2. I avoid driving at night because of glare from headlights and / or streetlights.
☐	☐	3. I no longer drive because of poor vision and difficulties with glare.
☐	☐	4. Fluorescent lights makes reading, shopping, and/or other functions difficult.
☐	☐	5. I have difficulty reading small print because of decreased vision.
☐	☐	6. Blurred vision has made it difficult to do close-up work.
☐	☐	7. I have a hard time watching television because of decreased or blurred vision.
☐	☐	8. Blurred vision from sunlight makes it difficult to participate in outdoor activities.
☐	☐	9. Glare from sunlight makes it difficult to participate in outdoor activities.
☐	☐	10. Poor vision causes difficulty with many of my daily activities.
☐	☐	11. I have noticed an imbalance in the vision between my eyes.
☐	☐	12. Decreased or blurred vision has made it uncomfortable maneuvering stairs, curbs, and / or sidewalks.

What lifestyle activity has become difficult because of decreased, blurred, or glared vision? _____

_____

Do you have any of the following eye symptoms?

□ Redness □ Burning □ Itching □ Excess Tearing / Watering Eyes
□ Eye Fatigue □ Foreign Body Sensation □ Dryness

Patient's Name: _____ Patient's Signature: _____ Date: _____

Surgeon's Signature: _____