Adult Patient Questionnaire:

- **Please disregard if patient is under 18 years of age**

Name:_____

Date of Birth:_____

Please answer the following questions by circling YES or NO

1. Do you have any problems driving at night- **YES** **NO**

    a. Do car headlights bother you? **YES** **NO**

2. Do you have issues with glare from lights? **YES** **NO**

3. Having any issues watching television? **YES** **NO**

4. Do you have issues reading books or small print? **YES** **NO**

5. Are you needing an exam for a Driver's license or CDL renewal?

YES **NO**