Vision Form for Disability Evaluation

Name of Claimant:
SSN:

Diagnosis:

Right eye

Left eye

Pseudophakia:	Right eye:	YES_____	NO_____	
	Left eye:	YES_____	NO_____	
Visual Acuity:	Distance (Without correction)	NEAR	DISTANCE (With correction)	NEAR
Right eye:	_____	_____	_____	_____
Left eye:	_____	_____	_____	_____

Is there any abnormality or limitation of field of vision?

YES_____ NO_____

Of yes, what is the widest diameter in degrees in remaining fields? (Please include copies of field tests)

Right eye:_____ Left eye:_____

Will visual function by impaired by prolonged or occasional:

Detailed vision:	YES_____	NO_____
Lifting:	YES_____	NO_____
Irritants:	YES_____	NO_____

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Is the patient able to see clearly enough for the following activities?

Driving a motor vehicle?	YES_____	NO_____
Operating machinery?	YES_____	NO_____
Reading small print?	YES_____	NO_____
Reading large print?	YES_____	NO_____
Eye-hand coordination tasks?	YES_____	NO_____
Identifying details at close range?	YES_____	NO_____
Working with a computer?	YES_____	NO_____
Avoid the ordinary hazards in the workplace, such as boxes on the floor, doors ajar, or approaching people or vehicles?	YES_____	NO_____

Does the patient have any complaints of any of the following:

_____ Blurred vision
_____ Loss of vision
_____ Obstruction of vision
_____ Eye pain
_____ Other

Additional comments:

Physician's signature: Date:

Print name:

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