



# Visual Function and Corneal Health Status (V-FUCHS)

Form content retained in medical record.  
**Discard after electronic entry.**

(complete fields or place patient label here)

Patient Name (First, Middle, Last)	
Birth Date (mm-dd-yyyy)	Room Number (if applicable)
Mayo Clinic Number	

## BACKUP

Outage Date \_\_\_\_\_ Outage Time \_\_\_\_\_  
(mm-dd-yyyy) (hh:mm 24-hour clock)

### Your Vision in Everyday Life

You are being asked to answer the following questions because we want to understand how your eyesight limits your everyday life. It takes about five minutes to complete the questions.

When you answer the following questions we ask you to think only of the difficulties that your sight may be causing you. Please only consider the impact of your sight, and not other problems, in your ability to perform the following tasks.

If you wear glasses or contact lenses for a particular activity, please answer all of the following questions as though you were wearing your best glasses or contact lenses if necessary.

How often do you have each of the following difficulties? For each question, please select the response that corresponds best to your situation (while wearing your best glasses or contact lenses if necessary).	Never	Rarely	Sometimes	Most of the time	All of the time
During the past month, my eyesight changed over the course of the day.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the past month, I have had blurred vision that is worst in the morning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the past month, I have had trouble with focusing that is worst in the morning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At night, bright lights look like a starburst.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At night, a bright circle (halo) appears to surround lights, such as street lights.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall, fine details are becoming harder to see, for example, leaves on trees.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the past month, my vision interfered with my daily activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Because of your eyesight, how much difficulty do you have? For each question, please select the response that corresponds best to your situation (while wearing your best glasses or contact lenses if necessary).	No difficulty	A little	Moderate	A lot	Extreme difficulty
Reading ordinary print on paper?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading text on a screen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing work or hobbies that require you to see well up close?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading text on medicine bottles and package inserts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing the prices of items when shopping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing what is ahead of you when you enter from daylight into a shady area, such as entering into a parking ramp?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing what is ahead of you when an oncoming car has headlights on at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing what is ahead of you when the sun is low during sunrise or sunset?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Wacker K, Baratz KH, Bourne WM, Patel SV. Patient-Reported Visual Disability in Fuchs Endothelial Corneal Dystrophy Measured by the Visual Function and Corneal Health Status Instrument. *Ophthalmology* 2018;125(12):1854-1861.