QUALITY OF VISION QUESTIONNAIRE FOR PILOT/ATCS

(Updated 08/27/2025)

The following questions should be answered by the PILOT/ATCS. Complete all sections as appropriate. Please add additional comments at the bottom as necessary. Bring this page to your AME for upload into your file as **Eye – Quality of Vision Questionnaire**.

A. Do you have any of these visual symptoms? (Circle) Blurred vision Glare Halos Starbursts Loss of contrast	NO	YES*
B. Do the symptoms impair your visual functioning? (If no symptoms, mark "NO")	NO	YES*
C. Do you notice any areas of your vision that are distorted, dark, or missing? (Central vision or peripheral field of vision.)	NO	YES*
D. Do you have difficulty driving at night or in low light conditions due to your vision?	NO	YES*
E. Do you have double vision (diplopia) in any direction of gaze or under any special condition such as fatigue? If YES, describe in the space below what you see (ex. prisms, etc.) and any treatments.	NO	YES*
F. Do you have any history of past or current abnormalities affecting your eyes or vision? (Check "YES" even if resolved).	NO	YES*
G. Have you ever had any eye-related procedures/surgery? Include intraocular, refractive, orbit, eyelid, lasers, injections, corneal sculpting with contacts, etc.	NO	YES*
H. Have you ever been told you have weakness with color vision?	NO	YES*
I. Are you taking any medication(s) for your eyes?	NO	YES*

If you responded YES* to any above questions, please explain below. Include how often, how severe, and does it affect your day-to-day activities. Please enter additional explanation or comments for ANY part of this questionnaire:

Pilot/ATCS Name _____ MID#, PI#, or App ID#_____

Pilot/ATCS Signature _____ Date completed _____