MARYLANDVISION CENTER
MEDICAL & SURGICAL EYE CARE

Cataract Lens Questionnaire

1. **After surgery, would you be interested in seeing well without glasses in this situation?**

Distance Vision (driving, watching television, golf, tennis, sports activities of any sort).

____ Prefer no distance glasses ____ I don't mind wearing distance glasses.

Mid-range vision (computer, price tags, cooking, board games, viewing shelf items, shaving, makeup application, and dashboard).

____ Prefer no mid-rage glasses ____ I don't mind wearing mid-rage glasses.

Near Vision (reading, detailed handwork hobbies).

____ Prefer no near glasses ____ I don't mind wearing near glasses.

2. **If you had to wear glasses following surgery for activities, which scenario would you be most willing to use glasses?**

____ Distance Vision ____ Mid-range Vision ____ Near Vision

3. **Which statement best describes your night vision expectations?**

____ I require the best possible night vision as it is extremely important to me.
____ I want to be able to drive comfortably but can tolerate some imperfections.
____ Nigh vision is not important to my current lifestyle.

4. **Cataract surgery is covered by insurance. Surgery to reduce your spectacle independence for distance, mid-range and near vision may be only partially covered by medical insurance. These additional features will require supplemental out of pocket expenses. Is this something you would be interested in?**

____ Yes ____ No ____ Maybe, depends on the cost

5. **Please mark the scale describing your personality.**

[________________________________x________________________________]
Easy going Perfectionist

Printed Name: ____

Signature: ___________________________________ Date: _____________

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Cataract Questionnaire

Do you have difficulty, even with glasses, with the following activities?

1. - Reading small print, such as labels on medicine bottles, food labels, telephone books? ______________________ YES / NO

2. - Doing fine hand work like sewing, knitting or carpentry? _____ YES / NO

3. - Playing games such as bingo, dominos, or card games? _____ YES / NO

4. - Reading newspapers, books or Computer screen? _________YES / NO

5. - Recognizing people from a distance? __________________ YES / NO

6. - Taking part in sports like bowling, handball, tennis, or golf? ___ YES / NO

7. - Watching Television? ______________________________YES / NO

8. - Reading traffic signs, street signs or seeing oncoming cars? __ YES / NO

Has your vision:

1. - Caused you difficulty with doing house work? _____________ YES / NO

2. - Caused you difficulty with doing your job? ________________ YES / NO

3. - Caused you difficulty with doing your hobbies? ____________ YES / NO

4. - Caused you difficulty with Driving at night? _______________ YES / NO

5. - Caused you to be concern about bumping into something or falling? _____________________________________ YES / NO

6. - Caused a decreased in your level of independence? ________ YES / NO

Have you been bothered by:

1. - Glared caused by headlights or bright sunlight? ____________YES / NO

2. - Seeing Rings or Halos around lights? ____________________YES / NO

3. - Hazy and/ or Blurry vision? ___________________________YES / NO

Name: _______________________________ ***DOB:*** _______________