



Cataract Patient Questionnaire

Name: _____ Date: _____ Eye Being Evaluated RT LT

There are a variety of options for cataract surgery that will not only give you clearer vision, but can also reduce your dependency on glasses. Each option has potential advantages and disadvantages, depending on your lifestyle and the activities you enjoy. Please help us to better understand what is important to you in order to determine which option is best suited for your lifestyle and eye health.

What is (or was) your occupation? _____

Visual Functioning

Do you have difficulty, even with glasses, with the following activities?	YES	NO
1. Reading small print, such as labels on medicine bottles, telephone books, or food labels?	<input type="checkbox"/>	<input type="checkbox"/>
2. Reading a newspaper or book?	<input type="checkbox"/>	<input type="checkbox"/>
3. Reading a large-print book, or large-print newspaper, or large numbers on a phone?	<input type="checkbox"/>	<input type="checkbox"/>
4. Recognizing people when they are close to you?	<input type="checkbox"/>	<input type="checkbox"/>
5. Seeing steps, stairs, or curbs?	<input type="checkbox"/>	<input type="checkbox"/>
6. Reading traffic signs, street signs, or store signs?	<input type="checkbox"/>	<input type="checkbox"/>
7. Doing fine handwork like sewing, knitting, crocheting, or carpentry?	<input type="checkbox"/>	<input type="checkbox"/>
8. Writing checks or filling out forms?	<input type="checkbox"/>	<input type="checkbox"/>
9. Playing games such as bingo, dominos, or card games?	<input type="checkbox"/>	<input type="checkbox"/>
10. Taking part in sports like bowling, handball, tennis, or golf?	<input type="checkbox"/>	<input type="checkbox"/>
11. Cooking?	<input type="checkbox"/>	<input type="checkbox"/>
12. Watching television?	<input type="checkbox"/>	<input type="checkbox"/>

Symptoms

Have you been bothered by:	YES	NO
1. Poor night vision?	<input type="checkbox"/>	<input type="checkbox"/>
2. Seeing rings or halos around lights?	<input type="checkbox"/>	<input type="checkbox"/>
3. Glare caused by headlights or bright sunlight?	<input type="checkbox"/>	<input type="checkbox"/>
4. Hazy and/or blurry vision?	<input type="checkbox"/>	<input type="checkbox"/>
5. Seeing well in poor or dim light?	<input type="checkbox"/>	<input type="checkbox"/>
6. Poor color vision?	<input type="checkbox"/>	<input type="checkbox"/>
7. Double vision?	<input type="checkbox"/>	<input type="checkbox"/>

Driving

1. Have you ever driven a car? YES (continue) NO (stop)
2. Do you currently drive a car? YES (continue) NO (stop)
3. How much difficulty do you have driving during the day because of your vision?
 No difficulty A moderate amount of difficulty
 A little difficulty A great deal of difficulty
4. How much difficulty do you have driving at night because of your vision?
 No difficulty A moderate amount of difficulty
 A little difficulty A great deal of difficulty
5. When did you stop driving?
 Less than 6 months ago 6-12 months ago More than 1 year ago

Other Activities

1. How many combined hours per day do you spend on a computer, tablet, and/or smartphone? _____
2. Please share anything else you think might be important about your lifestyle or daily activities: _____

3. Are there times in your day that you wish you didn't have to wear glasses? YES NO

If yes, explain when: _____

4. After surgery, would you be interested in seeing well **without glasses** in the following situations?

Distance Vision (driving, golf, tennis, other sports, watching television)

___ I prefer no distance glasses ___ I wouldn't mind distance glasses ___ I want distance glasses

Mid-range Vision (computer, menus, price tags, cooking, board games, items of a shelf)

___ I prefer no mid-range glasses ___ I wouldn't mind mid-range glasses ___ I want mid-range glasses

Near Vision (reading books, smartphones, tablets, e-readers, sewing, carpentry)

___ I prefer no near glasses ___ I wouldn't mind near glasses ___ I want near glasses

5. If you had to wear glasses after surgery, for which activity would you be **most** willing to use glasses?

___ **Distance vision** ___ **Mid-range vision** ___ **Near vision**

6. Please place an "X" on the following scale that best describes your personality:

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Easy Going

Perfectionist

Patient signature: _____