CATARACT PATIENT QUESTIONNAIRE

Pre-surgical

Name: _____

Chart #: _____

Date: _____

☐RIGHT or ☐LEFT EYE – Complete for the eye that is the worst.

VISUAL FUNCTIONING

Do you have difficulty, even with glasses, with the following activities?	**YES**	**NO**
• Reading small print, such as labels on medicine bottles, telephone books, or food labels?	☐	☐
• Reading a newspaper or book?	☐	☐
• Reading a large-print book, or large-print newspaper, or large numbers on a telephone?	☐	☐
• Recognizing people when they are close to you?	☐	☐
• Seeing steps, stairs or curbs?	☐	☐
• Reading traffic signs, street signs, or store signs?	☐	☐
• Doing fine handwork like sewing, knitting, crocheting, or carpentry?	☐	☐
• Writing checks or filling out forms?	☐	☐
• Playing games such as bingo, dominos, or card games?	☐	☐
• Taking part in sports like bowling, handball, tennis, or golf?	☐	☐
• Cooking?	☐	☐
• Watching television?	☐	☐

SYMPTOMS

Have you been bothered by?

	YES	**NO**
• Poor night vision?	☐	☐
• Seeing rings or halos around lights?	☐	☐
• Glare caused by headlights or bright sunlight?	☐	☐
• Hazy and/or blurry vision?	☐	☐
• Seeing well in poor or dim light?	☐	☐
• Poor color vision?	☐	☐
• Double vision?	☐	☐

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 little difficulty
   - ☐ A moderate amount of difficulty
   - ☐ A great deal of difficulty
4. How much difficulty do you have **driving at night** because of your vision?
   - ☐ No difficulty
   - ☐ A little difficulty
   - ☐ A moderate amount of 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

Cataract surgery can almost always be safely postponed until you feel you need better vision. If stronger glasses won't improve your vision anymore, and if the only way to help you see better is cataract surgery, do you feel your vision problem is bad enough to consider cataract surgery now?

☐ YES ☐ NO

Patient Signature: _____ **Date:** _____

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Patient : _____ DOB : _____ Date : _____

Specialty Lens Implant Questionnaire

Completing the following questionnaire will assist the doctor in determining which, if any, of the specialty lens implants is more appropriate for you.

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

Distance vision (driving, golf, tennis, other sports, watching TV)
___ Prefer no distance glasses.
___ Not important, I wouldn't mind wearing distance glasses

Mid-range vision (computer, menus, price tags, cooking, items on a shelf)
___ Prefer no Mid-range glasses
___ Not important, I wouldn't mind wearing Mid-range glasses

Near vision (reading books, newspapers, magazines, sewing)
___ Prefer no Near glasses
___ Not important, I wouldn't mind wearing Near glasses

Please check the single statement that best describes your **night vision**:

___ Night vision is very important to me; I require the best possible quality night vision

___ I want to be able to drive comfortably at night; I would tolerate some imperfections

___ Night vision is not important to me

If you **had** to use glasses after surgery, for which activity would you be most willing:

___ Distance ___ Mid-range ___ Near

If you could have good **distance vision during the day** without glasses, and good **near vision for reading** without glasses, but the tradeoff was that you might see some **halos or rings** around lights at night would you like that option? ___ yes ___ no

If you could have good **distance vision during the day and night** without glasses, and good **Mid-range vision** without glasses, but the tradeoff was that you might need glasses for reading at near, would you like that option?
___ yes ___ no

Place an "X" on the scale to describe your motivation to be less dependent on glasses
Prefer glasses at all times somewhat interested I hate glasses!!

❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑
1 5 10

Place an "X" on the following scale to describe your personality as best as you can
Easy Going Perfectionist

❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑
1 5 10

Please list your occupation and hobbies: _____

_____