

**Pre-surgical Cataract Patient Questionnaire**

**Eye to be evaluated:** \_\_\_\_\_

**Visual Functioning:**

<b>Do you have difficulty, even with glasses, with the following activities?</b>	<b>Which eyes?</b>		
	<b>Left</b>	<b>Right</b>	<b>Both</b>
1. Reading small print, such as labels on medicine bottles, telephone books, or food labels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Reading a newspaper or book?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Reading traffic signs, street signs, or store signs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Doing fine handiwork like sewing, knitting, crocheting, or carpentry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Taking part in sports like bowling, golf, or tennis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Difficulty driving?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Difficulty/avoid driving at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Watching television?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have difficulty performing daily activities? If so please list: _____			

**Symptoms**

<b>Have you been bothered by:</b>	<b>Which eyes?</b>		
	<b>Left</b>	<b>Right</b>	<b>Both</b>
1. Poor night vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Seeing rings or halos around lights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Glare caused by headlights, street lights, or bright sunlight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Hazy and / or blurry vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Seeing in poor or dim light?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Poor color vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Double vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Poor depth perception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Limited visual field?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

YES

NO

**Which would best describe you?**

- Wouldn't mind wearing glasses       Would prefer no glasses after surgery after surgery

**If you could have good distance and mid-range vision without glasses, but you might see some halos or rings around lights at night and/or need over-the-counter readers for fine print, would that be acceptable?**

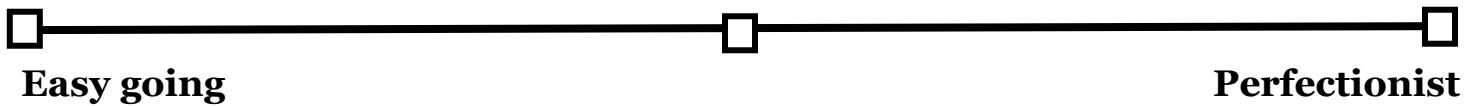
YES

NO

**What is your primary occupation?**

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**Please place an "X" on the following scale to describe your personality**



**Signature:** \_\_\_\_\_