

**Pre-Surgical Cataract
Patient Questionnaire**

Patient's Name _____

Eye being evaluated:

Right

Left

Both

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 telephone? | <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 handiwork 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, golf or tennis? | <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, street lights, 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

Have you ever driven a car? YES (continue) NO (stop here)

Do you currently drive a car? YES (continue) NO (stop here)

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

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

Have you stopped driving at night? If so, how long ago did you stop?

- Less than six months ago six - 12 months ago
 More than one year ago

If you have cataract surgery, you can use this opportunity to reduce your dependency on eyeglasses by trying to correct vision problems you were born with, like astigmatism, or problems you developed later in life, like presbyopia (the need for reading glasses). This requires purchasing an upgrade to a Premium Intraocular Lens. (Premium lenses are not covered by health insurance.) Does this interest you?

- Yes, I would like to use this opportunity to correct a long-standing vision problem.
 Astigmatism (Distorts vision and makes things blurry)
 Presbyopia (the need to use reading glasses or bifocals)
- No, this doesn't interest me. I do not mind wearing eyeglasses. I'd prefer the simplest and least expensive operation I can have.

Cataract surgery can almost always be safely postponed until you feel you need better vision. If stronger glasses won't improve your vision any more, 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