

**PRE-SURGICAL CATARACT PATIENT QUESTIONNAIRE**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Please indicate whether you experience the following symptoms in your right and/or left eye.**

VISUAL FUNCTIONING – Do you have difficulty with the following activities (even with glasses)?	NO	YES	
		RIGHT EYE	LEFT EYE
1. Reading small print (i.e. labels on medication bottles, telephone books, food labels, etc.)	<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 a large-print book, large-print newspaper, or large numbers on a telephone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Recognizing people when they are in close proximity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Seeing steps, stairs, or curbs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Reading traffic signs, street signs, or store signs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Doing fine handwork (i.e. sewing, knitting, crocheting, carpentry, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Writing checks or filling out forms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Playing games (i.e. bingo, dominos, card games, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Taking part in sports (i.e. bowling, handball, tennis, golf, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Cooking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Watching television?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Depth perception and trouble judging distance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SYMPTOMS – Have you been bothered by:**

	NO	RIGHT EYE	LEFT EYE
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 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 well in poor or dim light?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Distinguishing color?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Double vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**DRIVING – Do you currently drive a car and/or operate a vehicle?**

**NO**    1. When did you stop driving?     Less than 6 months ago     6-12 months ago     More than 1 year ago

**YES**

1. How much difficulty do you have **driving during the day**, because of your vision?  
 No difficulty     Little difficulty     Moderate difficulty     Great difficulty

2. How much difficulty do you have **driving at night**, because of your vision?  
 No difficulty     Little difficulty     Moderate difficulty     Great difficulty

**LIFESTYLE**

1. Describe the activities of your work and/or extracurricular life (i.e. sewing, golf, computer, paperwork, etc.)  
\_\_\_\_\_

2. What activities are you currently unable to perform, due to your current state of vision?  
\_\_\_\_\_

3. How motivated are you to perform the activities listed above without glasses, after your cataract procedure?  
 1 – Not Motivated     2     3     4     5 – Very Motivated

4. Are you aware of the technology options for cataract surgery to reduce and/or eliminate your need for glasses or contact lenses after the procedure?     NO     YES

5. If considered a candidate for cataract surgery, what are your visual expectations after surgery?  
\_\_\_\_\_

6. What concerns do you have about cataract surgery? \_\_\_\_\_

7. If considered a candidate for cataract surgery, how soon are you looking to schedule your procedure?  
\_\_\_\_\_

**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 cataract surgery, do you feel your vision problem is bad enough to consider cataract surgery now?**

	NO	YES	
		RIGHT EYE	LEFT EYE
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature: \_\_\_\_\_ Date: \_\_\_\_\_