

Patient Name: _____

Eye Being Evaluated: Right Left

CATARACT PRE-SURGICAL LIFESTYLE QUESTIONNAIRE

Visual Functioning

Do you have difficulty, even with glasses, with the following activities?

- Reading small print, pill bottle labels or the telephone book? Yes No
- Reading a newspaper or book? Yes No
- Reading a large print book or large print newspapers or numbers? Yes No
- Recognizing people when they are close to you? Yes No
- Seeing steps, stairs or curbs? Yes No
- Reading traffic signs, street signs, or store signs? Yes No
- Doing fine handwork like sewing, knitting, or carpentry? Yes No
- Writing checks or filling out forms? Yes No
- Playing games such as bingo, dominos or card games? Yes No
- Shaving or putting on your make up Yes No
- Cooking? Yes No

Symptoms

Have you been bothered by:

- Poor night vision? Yes No
- Seeing rings or halos around lights at night while driving? Yes No
- Glare caused by headlights or bright sunlight? Yes No
- Hazy and/or blurry vision? Yes No
- Seeing well in poor or dim light? Yes No
- Poor color vision? Yes No
- Double vision? Yes No

Driving

Do you currently drive a car? Yes No

Do you do a lot of night driving? Yes No Somewhat

How much difficulty do you have **driving during the day** because of your vision?

- No difficulty moderate difficulty A little difficulty A great deal of difficulty

How much difficulty do you have **driving at night** because of your vision?

- No difficulty moderate difficulty A little difficulty A great deal of difficulty

When did you stop driving? last 6 months 6-12 months ago Over 1 year ago Never

Lifestyle Considerations

What is *or* was your **occupation**? _____

Please list your **favorite hobbies**? _____

What sporting / recreational / outdoor activities do you? _____

Do you use a **computer** frequently? Yes No Somewhat

Do you do a lot of **close detailed work**? Yes No Somewhat

Have you ever tried **monovision** contact lenses? Yes No Now using

If "yes", did/do you like it? Yes No

Do you wear progressive/no-line **bifocals** now? Yes No

Over your lifetime, have you generally been **satisfied with your vision with prescription glasses**?

..... Yes No

If "no", please explain: _____

Would you like to have, without glasses, good **distance and near vision** in good light, even if you might see some **rings** around lights at night? Yes No Maybe

Have you had **LASIK**? Yes No

Do you have any **specific vision concerns**? _____

Cataract surgery can be safely postponed until you feel you need better vision. If stronger glasses will not improve your vision, and if the only way to see better is cataract surgery, then do you feel your vision problem is bad enough to require cataract surgery now?

Yes

No

Patient's Signature: _____ **Date:** _____