

Pre Surgical Cataract Patient Questionnaire

PATIENT NAME: _____

D.O.B. _____

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 a 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 handwork 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, handball, tennis or golf? | <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 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 from one eye? | <input type="checkbox"/> | <input type="checkbox"/> |

Pre Surgical Cataract Patient Questionnaire - continued

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 moderate amount of difficulty
 A little difficulty A great deal of difficulty

4. 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

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** _____