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DISEASES AND SURGERY OF THE EYE

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Cataract and IOL Options Questionnaire

1. Are you interested in not having to wear glasses after cataract surgery?

   ____________ Yes ____________ No

2. Are you interested in seeing well **at distance** without glasses after surgery?

   ____________ Prefer no distance glasses

   ____________ I wouldn't mind wearing distance glasses

3. Are you interested in seeing well **at near** without glasses after surgery?

   ____________ Prefer no reading glasses

   ____________ I wouldn't mind wearing reading glasses

4. If you **had** to wear glasses after surgery for one activity, for which activity would you be **most** willing to use glasses?

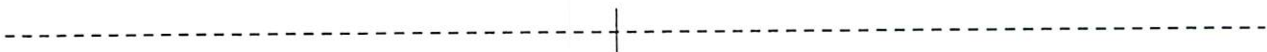
   ____________ Reading fine print ____________ Computer ____________ Driving

5. If you could have good **distance vision during the day** without glasses, and good **near** vision for reading without glasses, but the compromise was that you might see some **halos** around lights at night, would you like that option?

   ____________ Yes ____________ No

6. Please place an "X" on the following scale to describe your personality as best you can:

Easy Going *Perfectionist*



Patient Questionnaire for Cataract Surgery

Patient Name: ______________________________

Record No.: ______________________________

What specific improvements in your activities or current restrictions in participation do you hope to gain with surgery?

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Visual Functional Status *(Circle bracketed specifics as appropriate)* ***Circle***

1) Do you have difficulty seeing street signs or seeing to drive? [curbs, freeway exits, traffic lights, halos/glare around lights] YES NO
2) Do you have difficulty seeing TV or movies? [faces, numbers, or printing] YES NO
3) Do you have difficulty reading small print with good light, complete blinking and proper glasses? [books, newspaper, telephone book, medicine labels, instructions] YES NO
4) Do you have difficulty performing detailed work? [sewing, knitting, crocheting, embroidery, baiting a fish hook or other fine tasks] YES NO
5) Do you have difficulty with personal correspondences? [writing checks, reading bills, filling out forms] YES NO
6) Do you have difficulty with leisure activities such as sports or hobbies? (playing card games, bingo, dominoes, or activities such as bowling, hunting, golf, tennis, other ________________) YES NO
7) Do you have visual difficulty functioning around the house? (cooking, ironing, general household upkeep, climbing steps/curbs, dialing a telephone, telling time on a watch, using public transportation) YES NO
8) Do you have difficulty recognizing faces of people? (in church, grocery store, clubs, and other daily activities) YES NO
9) If you live alone and wish to remain independent, are you unable to care for yourself with your present vision? YES NO

Do you have any of the following <u>VISUAL SYMPTOMS</u>?

1) Double or distorted vision? YES NO
2) Glare, halos, rings around lights? YES NO
3) Difficulty with color perception? YES NO
4) Difficulty with depth perception? YES NO
5) Worsening of vision – blurred vision? YES NO

Patient's Signature ______________________________________