Pre-Surgical Cataract
Patient Questionnaire

Patient Name:
Account #:

Visual Functioning

Do you have difficulty, even with glasses, with the following activities? Check YES or NO.

	Right Eye	*Left Eye*
1. Reading small print, such as labels on medicine	❑ YES ❑ NO	❑ YES ❑ NO
2. Bottles, telephone books, or food labels?	❑ YES ❑ NO	❑ YES ❑ NO
3. Reading a newspaper or book?	❑ YES ❑ NO	❑ YES ❑ NO
4. Reading a large-print book, large-print newspapers, or large numbers on a telephone?	❑ YES ❑ NO	❑ YES ❑ NO
5. Recognizing people when they are close to you?	❑ YES ❑ NO	❑ YES ❑ NO
6. Seeing steps, stairs, or curbs?	❑ YES ❑ NO	❑ YES ❑ NO
7. Reading traffic signs, street signs, or store signs?	❑ YES ❑ NO	❑ YES ❑ NO
8. Doing fine handworks like sewing, knitting, crocheting, or carpentry?	❑ YES ❑ NO	❑ YES ❑ NO
9. Writing checks or filling out forms?	❑ YES ❑ NO	❑ YES ❑ NO
10. Playing games such as bingo, dominos, or card games?	❑ YES ❑ NO	❑ YES ❑ NO
11. Taking part in sports like bowling, handball, tennis, or golf?	❑ YES ❑ NO	❑ YES ❑ NO
12. Cooking?	❑ YES ❑ NO	❑ YES ❑ NO
13. Watching television?	❑ YES ❑ NO	❑ YES ❑ NO

Symptoms

Have you been bothered by: Check YES or NO.	*Right Eye*	*Left Eye*
1. Poor Night Vision?	❑ YES ❑ NO	❑ YES ❑ NO
2. Seeing rings or halos around light?	❑ YES ❑ NO	❑ YES ❑ NO
3. Glare caused by headlights or bright sunlight?	❑ YES ❑ NO	❑ YES ❑ NO

4. Hazy and/or blurry vision?	❑ YES ❑ NO	❑ YES ❑ NO
5. Seeing well in poor or dim light?	❑ YES ❑ NO	❑ YES ❑ NO
6. Poor Color Vision?	❑ YES ❑ NO	❑ YES ❑ NO
7. Double Vision?	❑ YES ❑ NO	❑ YES ❑ NO

Driving

	Right Eye	*Left Eye*
1. Have you ever driven a car?	❑ YES (Continue) ❑ NO (Stop)	❑ YES (Continue) ❑ NO (Stop)
2. Do you currently drive a car?	❑ YES (Continue) ❑ NO (Stop)	❑ YES (Continue) ❑ NO (Stop)
3. How much difficulty do you drive during the day because of your vision?	❑ No difficulty ❑ A little difficulty ❑ A moderate amount of difficulty ❑ A great deal of difficult	❑ No difficulty ❑ A little difficulty ❑ A moderate amount of difficulty ❑ A great deal of difficult
4. How much difficulty do you have driving at night because of your vision?	❑ No difficulty ❑ A little difficulty ❑ A moderate amount of difficulty ❑ A great deal of difficult	❑ No difficulty ❑ A little difficulty ❑ A moderate amount of difficulty ❑ A great deal of difficult
5. When did you stop driving?	❑ Less than 6 months ago ❑ 6-12 months ago ❑ More than 1 year ago	❑ 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:*** _____

Witness: _____ ***Date:*** _____