Visionary Eye Doctors
Advanced technology with a loving touch

Cataract Lifestyle Questionnaire

Name _____

You have an important decision to make about your vision future.

This questionnaire is designed to help us understand your vision goals so we can provide you the best possible lens for your lifestyle.

1. **Throughout the day, you perform activities that require your eyes to focus at different distances.**

Circle or write in the activities that are most important to your lifestyle:

Distance

 Driving |  Golfing |  Sporting events |  Scenery

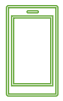
Other: _____

Intermediate

 Car Dashboard |  Computer |  Shopping |  Games

Other: _____

Near

 Fine Print |  Cell Phone |  Sewing |  Makeup

Other: _____

2. **Over average, how many hours per day do you spend:**

___Driving	___Engaging in lifestyle activities (i.e., golf, gardening, cooking, etc.)	___Using Media devices (i.e., mobile phone, tablet, e-reader)	___Reading books, newspaper	___Knitting, reading, fine print

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3. **Thinking long-term, how important is it that you rely on your glasses less often?**

   ❑ I don't mind ❑ It'd be nice ❑ Glasses are annoying ❑ I hate wearing them

4. **How often do you drive in low-light conditions (dusk, night, dawn, rain)?**

   ❑ Never ❑ Not often, but I'd like to ❑ Occasionally ❑ Often

5. **As best you can, mark where your personality type fits on this scale.**

   Easygoing ——— Perfectionist

6. **I know that my insurance may only cover some of the procedures, and I want to learn about my treatment options.**

   ❑ Agree

   ❑ Disagree

7. **If my procedure is not fully covered by insurance. I want to learn about financing options.**

   ❑ Agree

   ❑ Disagree

8. **To ensure your visit is a great experience, please share any questions or concerns you would like us to know about.**

   _____

   _____