LIFESTYLE AND VISION QUESTIONNAIRE

Patient Name:_____ **Date:**_____

If employed, what is your occupation?_____

What activities do you enjoy or do frequently?

_____reading _____computer _____watching TV

_____sewing _____shopping _____driving

_____playing cards _____cooking _____watching/playing sporting events

Other (please list):_____

_____

Do you have difficulty with any of the following activities?

_____reading, sewing, or other near activities _____working on my computer

_____seeing/reading road signs at a proper distance _____reading shopping labels

_____recognizing faces or seeing the clock across the room

Have you experienced any of the following?

_____haloes, glare, or difficulty seeing at night _____difficulty with color perception

_____difficulty with depth perception _____overall decrease in vision

How important is the opportunity to do most of the activities you enjoy with a minimal need for glasses after cataract surgery?

_____Very Important _____Important _____Somewhat Important _____Not important

Would you accept seeing faint rings around headlights at night in exchange for being able to see better at all distances without glasses? _____Yes _____No

If your doctor determines you are an appropriate candidate for advanced technology currently available, would you like to hear about a lens that could significantly reduce or possibly eliminate the need for glasses following surgery?

_____Yes, I am interested _____ I might be interested _____No, I prefer to wear glasses

Place an "X" on the scale/line below where you would rate your personality:

_____

Easy Going — Perfectionist
Easy To Please — Demanding

Patient Signature:_____

FOR OFFICE USE ONLY:

OD: _____D @ _____

OS: _____D @ _____