LIFESTYLE AND VISUAL QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____ Today's Date: _____

If employed, what is your occupation? _____

What activities do you enjoy or do frequently?

_____ Reading _____ Computer _____ Watching TV

_____ Sewing _____ Driving _____ Watching/playing sporting events

_____ Playing Cards _____ Cooking

Other (please list): _____

Do you have difficulty with any of the following activities?

_____ Reading,sewing or any other near activities _____ Working on a computer/tablet

_____ Seeing/reading road signs at a proper distance _____ Driving

_____ Recognizing faces or seeing the clock across the room

Other (please list): _____

Have you experienced any of the following?

_____ Halos, glare or difficultly seeing at night _____ Difficulty with color perception

_____ Difficulty with depth perception _____ Overall decrease in vision

Other (please list): _____

Place an "X" on the line/scale below to describe your motivation to reduce your dependency on glasses:

I wouldn't mind wearing glasses after surgery; I only want what is covered by insurance

I want to see well at distance and near after surgery; I wouldn't mind paying extra for a reduced dependency on glasses

Please select the vision/activity which is most important to you following cataract surgery:

_____ Near vision activities, such as reading or sewing, with a reduced dependence on glasses.

_____ Intermediate vision activities, such as working on a computer/tablet or cooking, with a reduced dependence on glasses.

_____ Distance vision activities, such as driving or watching TV, with a reduced dependence on glasses.

_____ All of the activities above are important to me; I'm very motivated to decrease my dependency on glasses at all distances.

Place an "X" on the line/scale below to describe your personality as best you can:

Easygoing

Perfectionist

Patient Signature: _____

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