NVISION® EYE CENTERS

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PRE-SURGICAL CATARACT PATIENT QUESTIONNAIRE

Name: ______________________ **Date of Birth:** ______________________

Please indicate whether you experience the following symptoms in your right and/or left eye.

VISUAL FUNCTIONING – Do you have difficulty with the following activities (even with glasses)?	**NO**	**YES** RIGHT EYE	LEFT EYE
1. Reading small print (i.e. labels on medication bottles, telephone books, food labels, etc.)	☐	☐	☐
2. Reading a newspaper or book?	☐	☐	☐
3. Reading a large-print book, large-print newspaper, or large numbers on a telephone?	☐	☐	☐
4. Recognizing people when they are in close proximity?	☐	☐	☐
5. Seeing steps, stairs, or curbs?	☐	☐	☐
6. Reading traffic signs, street signs, or store signs?	☐	☐	☐
7. Doing fine handwork (i.e. sewing, knitting, crocheting, carpentry, etc.)?	☐	☐	☐
8. Writing checks or filling out forms?	☐	☐	☐
9. Playing games (i.e. bingo, dominos, card games, etc.)?	☐	☐	☐
10. Taking part in sports (i.e. bowling, handball, tennis, golf, etc.)?	☐	☐	☐
11. Cooking?	☐	☐	☐
12. Watching television?	☐	☐	☐
13. Depth perception and trouble judging distance?	☐	☐	☐
SYMPTOMS – Have you been bothered by:			
1. Poor night vision?	☐	☐	☐
2. Seeing rings or halos around lights?	☐	☐	☐
3. Glare caused by headlights or bright sunlight?	☐	☐	☐
4. Hazy and/or blurry vision?	☐	☐	☐
5. Seeing well in poor or dim light?	☐	☐	☐
6. Distinguishing color?	☐	☐	☐
7. Double vision?	☐	☐	☐

DRIVING – Do you currently drive a car and/or operate a vehicle?

☐ **NO** 1. When did you stop driving? ☐ Less than 6 months ago ☐ 6-12 months ago ☐ More than 1 year ago

☐ **YES** 1. How much difficulty do you have **driving during the day,** because of your vision?
☐ No difficulty ☐ Little difficulty ☐ Moderate difficulty ☐ Great difficulty

2. How much difficulty do you have **driving at night,** because of your vision?
☐ No difficulty ☐ Little difficulty ☐ Moderate difficulty ☐ Great difficulty

LIFESTYLE

1. Describe the activities of your work and/or extracurricular life (i.e. sewing, golf, computer, paperwork, etc.)
____
2. What activities are you currently unable to perform, due to your current state of vision?
____
3. How motivated are you to perform the activities listed above without glasses, after your cataract procedure?
☐ 1 – Not Motivated ☐ 2 ☐ 3 ☐ 4 ☐ 5 – Very Motivated
4. Are you aware of the technology options for cataract surgery to reduce and/or eliminate your need for glasses or contact lenses after the procedure? ☐ NO ☐ YES
5. If considered a candidate for cataract surgery, what are your visual expectations after surgery?
____
6. What concerns do you have about cataract surgery? ______________________
7. If considered a candidate for cataract surgery, how soon are you looking to schedule your procedure?
____

Cataract surgery can almost always be safely postponed until you feel you need better vision. If stronger glasses will not 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?	**NO**	**YES** RIGHT EYE	LEFT EYE
	☐	☐	☐

Signature: ______________________ **Date:** ______________________