Mountain View EyeCenter

PRE-SURGICAL CATARACT QUESTIONNAIRE

Patient Name: _____ **DOB:**_____

Eye Being Evaluated: ☐ Right eye ☐ Left eye

VISUAL FUNCTIONING

Do you have any <u>difficulty</u>, *<u>even with glasses</u>*, with the following activities?**

	YES	NO
1. Reading small print, such as labels on medicine bottles, telephone books, newspaper, book, or food labels?	☐	☐
2. Writing checks or filling out forms?	☐	☐
3. Reading a large-print book, large-print newspaper, or large numbers on a telephone?	☐	☐
4. Recognizing people when they are close to you?	☐	☐
5. Seeing steps, stairs, or curbs?	☐	☐
6. Reading traffic signs, street signs, or store signs?	☐	☐
7. Doing fine handwork like sewing, knitting, crocheting, or carpentry?	☐	☐
8. Seeing wildlife?	☐	☐
9. Sighting your gun or seeing your target while hunting?	☐	☐
10. Taking part in sports such as fishing, bowling, tennis, or golf?	☐	☐
11. Difficulty in the kitchen, cooking?	☐	☐
12. Watching television?	☐	☐

SYMPTOMS

Have you been bothered by:

	YES	NO
1. Poor vision at night or in dim lighting?	☐	☐
2. Seeing rings or halos around lights?	☐	☐
3. Glare caused by sun, ice, or snow?	☐	☐
4. Hazy or blurry vision?	☐	☐
5. Poor color vision?	☐	☐
6. Double vision?	☐	☐

DRIVING

	YES	NO
1. Have you ever driven a car?	☐	☐
2. Do you currently drive a car?	☐	☐

If you answered NO to question 1, please skip to the next page.
If you answered NO to question 2, please skip to 2c.
If you answered YES to question 2, please answer questions 2a-2b:

2a. How much difficulty do you have driving during the day because of your vision?

☐	No difficulty
☐	A little difficulty
☐	A moderate amount of difficulty
☐	A great deal of difficulty

2b. How much difficulty do you have driving in the dark because of your vision?

☐	No difficulty
☐	A little difficulty
☐	A moderate amount of difficulty
☐	A great deal of difficulty

2c. When did you stop driving? [Skip if you answered YES to question 2.]

☐	Less than 6 months ago
☐	6-12 months ago
☐	More than 1 year ago

VISUAL PREFERENCE

When you have a lens implant or refractive procedure, it is important to consider your individual vision and lifestyle preferences. Although it has not yet been determined if you are a candidate for any procedure, this questionnaire will help us make recommendations during your exam.

Which distance would be most comfortable for you to **not** wear glasses?

☐ **Near** (12-20 in)	☐ **Mid-Distance** (15-24 in)	☐ **Distance** (6-20 ft)
-Reading	-Shaving	-Watching TV
-Sewing	-Computer	-Driving
-Applying make-up	-Labels on shelves	-Watching movies
-Crosswork puzzles	-Cooking	-Golf
-Wood work	-Dialing the phone	-Hunting

If after cataract surgery, you could see **both** far away and close up without glasses, but the trade-off was that you would see halos around headlights, would you find this acceptable?

☐ YES ☐ NO

GLAUCOMA

	YES	NO
Have you ever been diagnosed with any form of glaucoma, or are you considered a glaucoma suspect?	☐	☐
Are you currently being treated with any glaucoma medications?	☐	☐
Have you ever undergone surgical intervention for the treatment of glaucoma (including laser treatments)?	☐	☐

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?

☐ **Yes** ☐ **No**

Patient Signature: X_____ Date: _____