Clemson Eye
Visual Health & Surgery

Lifestyle Questionnaire

Your Information

What is your name? _____ Eye being evaluated: Right ☐ Left ☐

Visual Functioning

Do you have difficulty, even with glasses, with the following activities?

Reading small print, pill bottle labels, newspapers, books or the telephone book? . . . Yes ☐ No ☐
Recognizing people when they are close to you? . . . Yes ☐ No ☐
Seeing steps, stairs or curbs? . . . Yes ☐ No ☐
Reading traffic signs, street signs, or store signs? . . . Yes ☐ No ☐
Doing fine handwork like sewing, knitting, or carpentry? . . . Yes ☐ No ☐
Writing checks or filling out forms? . . . Yes ☐ No ☐
Playing games such as bingo, dominos or card games? . . . Yes ☐ No ☐
Shaving or putting on your make up? . . . Yes ☐ No ☐
Cooking? . . . Yes ☐ No ☐

Symptoms

Have you been bothered by:

Poor night vision, color vision or double vision? . . . Yes ☐ No ☐
Hazy and/or blurry vision? . . . Yes ☐ No ☐
Seeing well in poor or dim light? . . . Yes ☐ No ☐
Do you currently drive a car? . . . Yes ☐ No ☐
Seeing rings or halos around lights at night while driving? . . . Yes ☐ No ☐
Glare caused by headlights or bright sunlight? . . . Yes ☐ No ☐
Do you do a lot of night driving? . . . Yes ☐ No ☐ Somewhat ☐

On a scale of 1-5 (where 1 is none and 5 is a great deal), how much difficulty do you have driving:

1	2	3	4	5	
☐	☐	☐	☐	☐	during the day because of your vision?
☐	☐	☐	☐	☐	during the night because of your vision?

Lifestyle Considerations

What is or was your occupation? _____

List your favorite hobbies, sporting / recreational / outdoor activities? _____

Do you use a computer frequently? . . . Yes ☐ No ☐ Somewhat ☐
Do you do a lot of close detailed work? . . . Yes ☐ No ☐ Somewhat ☐
Have you ever tried monovision contact lenses? . . . Yes ☐ No ☐ Now using ☐
If "yes", did/do you like it? . . . Yes ☐ No ☐
Do you wear progressive/no-line bifocals now? . . . Yes ☐ No ☐
Over your lifetime, have you generally been satisfied with your vision with prescription glasses? . . . Yes ☐ No ☐

If "no", please explain: _____

Would you like to have, without glasses, good distance and near vision in good light, even if you might see some rings around lights at night? . . . Yes ☐ No ☐ Maybe ☐
Have you had LASIK? . . . Yes ☐ No ☐

Do you have any specific vision concerns? _____

Cataract surgery can be safely postponed until you feel you need better vision. If stronger glasses will not improve your vision, and if the only way to see better is cataract surgery, then do you feel your vision problem is bad enough to require cataract surgery now? Yes ☐ No ☐

Name (print): _____ Date: _____
Patient / Guardian / Guarantor

Signature: _____