

## Your Information

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What is your name? \_\_\_\_\_

## Visual Functioning

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### 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

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### 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

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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.

Do you feel your vision problem is bad enough that you wish to have cataract surgery? Yes  No

Name (print): \_\_\_\_\_ Date: \_\_\_\_\_

Patient / Guardian / Guarantor

Signature: \_\_\_\_\_