PARAGON EYE ASSOCIATES

Cataract Patient Questionnaire

Name: _____ Date: _____ Eye Being Evaluated ☐ RT ☐ LT

There are a variety of options for cataract surgery that will not only give you clearer vision, but can also reduce your dependency on glasses. Each option has potential advantages and disadvantages, depending on your lifestyle and the activities you enjoy. Please help us to better understand what is important to you in order to determine which option is best suited for your lifestyle and eye health.

What is (or was) your occupation? _____

Visual Functioning

Do you have difficulty, even with glasses, with the following activities?	**YES**	**NO**
1. Reading small print, such as labels on medicine bottles, telephone books, or food labels?	☐	☐
2. Reading a newspaper or book?	☐	☐
3. Reading a large-print book, or large-print newspaper, or large numbers on a phone?	☐	☐
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. Writing checks or filling out forms?	☐	☐
9. Playing games such as bingo, dominos, or card games?	☐	☐
10. Taking part in sports like bowling, handball, tennis, or golf?	☐	☐
11. Cooking?	☐	☐
12. Watching television?	☐	☐

Symptoms

Have you been bothered by:	**YES**	**NO**
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. Poor color vision?	☐	☐
7. Double vision?	☐	☐

Driving

1. Have you ever driven a car? □ YES (continue) □ NO (stop)
2. Do you currently drive a car? □ YES (continue) □ NO (stop)
3. How much difficulty do you have driving during the day because of your vision?
   □ No difficulty □ A moderate amount of difficulty
   □ A little difficulty □ A great deal of difficulty
4. How much difficulty do you have driving at night because of your vision?
   □ No difficulty □ A moderate amount of difficulty
   □ A little difficulty □ A great deal of difficulty
5. When did you stop driving?
   □ Less than 6 months ago □ 6-12 months ago □ More than 1 year ago

Other Activities

1. How many combined hours per day do you spend on a computer, tablet, and/or smartphone? _____
2. Please share anything else you think might be important about your lifestyle or daily activities: _____

   _____

   _____
3. Are there times in your day that you wish you didn't have to wear glasses? YES NO

   If yes, explain when: _____
4. After surgery, would you be interested in seeing well **without glasses** in the following situations?

   Distance Vision (driving, golf, tennis, other sports, watching television)

   ____ I prefer no distance glasses ____ I wouldn't mind distance glasses ____ I want distance glasses

   Mid-range Vision (computer, menus, price tags, cooking, board games, items of a shelf)

   ____ I prefer no mid-range glasses ____ I wouldn't mind mid-range glasses ____ I want mid-range glasses

   Near Vision (reading books, smartphones, tablets, e-readers, sewing, carpentry)

   ____ I prefer no near glasses ____ I wouldn't mind near glasses ____ I want near glasses
5. If you had to wear glasses after surgery, for which activity would you be **most** willing to use glasses?

   ____ **Distance vision** ____ **Mid-range vision** ____ **Near vision**
6. Please place an "X" on the following scale that best describes your personality:

   [----------I----------]

   Easy Going Perfectionist

Patient signature: _____