

CENTRAL TEXAS EYE CENTER

PRE-SURGICAL CATARACT PATIENT QUESTIONNAIRE

Patient Name: _____ Date: _____

Reason for exam today (patient words) _____

What specific improvements in your daily life do you hope to gain with surgery? _____

Eye Being Evaluated: LEFT EYE RIGHT EYE This must be filled out for each surgery eye.

Visual Function Status

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

1. Reading small print, such as labels on medicine bottles, telephone books, or food labels? Yes No
2. Reading a newspaper or book? Yes No
3. Reading a large-print book, or large-print newspaper, or large numbers on a telephone? Yes No
4. Recognizing people when they are close to you? Yes No
5. Recognizing people from across a room? Yes No
6. Judging distance such as in seeing steps, stairs, or curbs? Yes No
7. Reading traffic signs, street signs, or store signs? Yes No
8. Doing fine handwork like sewing, knitting, crocheting, carpentry, baiting a hook or other fine tasks? Yes No
9. Writing checks, reading bills, filling out forms, or telling time on a watch? Yes No
10. Playing games such as bingo, dominoes, or card games? Yes No
11. Taking part in sports like bowling, handball, tennis, or golf? Yes No
12. General household upkeep, cooking, or ironing? Yes No
13. Seeing television or movies? Yes No
14. If you live alone and wish to remain independent, are you able to care for yourself with your present vision? Yes No

Visual Symptoms:

Have you been bothered by:

1. Poor night vision? Yes No
2. Seeing rings or halos around lights? Yes No
3. Glare caused by headlights or bright sunlight? Yes No
4. Glare on a cloudy day? Yes No
5. Hazy and/or blurry vision? Yes No
6. Seeing well in poor or dim light? Yes No
7. Poor color vision? Yes No
8. Double vision? Yes No

Pre-Surgical Cataract Patient Questionnaire

Driving

1. Do you currently drive a car? Yes (continue) No (go to question 4)

2. 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.

3. How much difficulty do you have **driving at night** because of your vision?

- No difficulty.
- A little difficulty.
- A moderate amount of difficulty.
- A great deal of difficulty.

4. When did you stop driving?

- Less than 6 months ago.
- 6 to 12 months ago.
- More than 1 year ago.

Answer only if you answered no to question 1.

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? Yes No

Patient Signature: _____