Vision Questionnaire

Patient Name: _____ Date: _____

CIRCLE YES or NO

1. Are you having blurred vision at distance?	YES	NO
2. Are you having blurred vision at near?	YES	NO
3. Are you having difficulty driving?	YES	NO
4. Any difficulty with sports activities?	YES	NO
5. Any difficulty with computer screens or phones?	YES	NO
6. Any difficulty seeing the TV?	YES	NO
7. Any problems with seeing at night, glare, or halos?	YES	NO
8. Any difficulty writing checks, fine handwork, cooking, or completing other things around the house?	YES	NO

If your vision problem is determined to be related to a cataract and it was removed, what would be your preferred type of vision after the surgery?

[ ] I wouldn't mind wearing glasses all the time

[ ] I would prefer having good distance vision without glasses and wouldn't mind wearing glasses to see up close or read

[ ] I would prefer to not wear glasses for distance or near

Please place an "X" on the following scale to describe your personality as best you can:

|----------[]----------|
Easy Going **Perfectionist**

I am interested in having my cataract surgery performed with a laser: YES NO

Patient Signature: _____

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