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## Cataract Patient Questionnaire

Patient Name _____	
Patient Chart Number _____	Eye Being Evaluated RE <input type="checkbox"/> LE <input type="checkbox"/>

### Visual Functioning

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

Circle One

- |                                                                                              |     |    |
|----------------------------------------------------------------------------------------------|-----|----|
| 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. Seeing steps, stairs, or curbs?                                                           | Yes | No |
| 6. Reading traffic signs, street signs or store signs?                                       | Yes | No |
| 7. Doing fine handwork like sewing, knitting, crocheting, or carpentry?                      | Yes | No |
| 8. Writing checks or filing out forms?                                                       | Yes | No |
| 9. Playing games such as bingo, dominoes, or card games?                                     | Yes | No |
| 10. Taking part in sports like bowling, handball, tennis, or golf?                           | Yes | No |
| 11. Cooking?                                                                                 | Yes | No |
| 12. Watching television?                                                                     | Yes | No |

### Symptoms

Have you been bothered by:

Circle One

- |                                                   |     |    |
|---------------------------------------------------|-----|----|
| 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. Hazy and/or blurry vision?                     | Yes | No |
| 5. Seeing well in poor or dim light?              | Yes | No |
| 6. Poor color vision?                             | Yes | No |
| 7. Double vision?                                 | Yes | No |

**Driving**

Circle One

- 1. Have you ever driven a car?                      Yes (continue)    No
- 2. Do you currently drive a car?                      Yes (continue)    No
- 3. 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
- 4. 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
- 5. When did you stop driving?
  - Less than 6 months ago
  - 6 to 12 months ago
  - More than 1 year ago

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 \_\_\_\_\_ Date \_\_\_\_\_