

Cataract Questionnaire

This checklist will assist us in providing the treatment best suited for your visual needs if it is determined that cataract surgery is appropriate for you. It is important that you understand that many patients still need to wear glasses for some activities after surgery but due to recent technological advances, we are now able to offer a possibility for you to be potentially free from glasses for most activities. Please fill this form out completely and give it to the doctor. If you have any questions, please let us know and we will be happy to assist you.

* Are you interested in seeing well **for distance** without glasses after surgery?

___ Prefer no distance glasses ___ Not important to me. I wouldn't mind wearing distance glasses.

* Are you interested in seeing well **for near** without glasses after surgery?

___ Prefer no reading glasses ___ Not important to me. I wouldn't mind wearing reading glasses.

We divide vision into 3 "Zones of Vision"

Zone 1	Zone 2	Zone 3
Reading	Shaving	Watching TV
Sewing	E-mailing	Driving
Applying Make-up	Reading Labels/Price Tags on Shelf	Watching movies
Solving Crossword Puzzles	Cooking	Golfing, skiing, sailing
Using Smart Phone	Using a Computer	Watching spectator sports

Which "Zone of Vision" is the **most** important to you? Please choose **only one** of the following three options:

___ Zone 1 ___ Zone 2 ___ Zone 3

4. If you **had** to wear glasses after surgery for one zone, for which zone would you be **most** willing to use glasses?

___ Zone 1 ___ Zone 2 ___ Zone 3

5. If you could have good **distance vision during the day** without glasses, and good **near** vision for reading without glasses, but the compromise was that you might see some **halos** around lights at night, would you like that option?

___ Yes ___ No

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

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

Easy going

Perfectionist

Please Sign Here _____