Cataract Questionnaire

Name:____ Date:___________________________

Yes	No	
☐	☐	Has your vision been getting progressively worse?
☐	☐	Do you have glare or halos around lights?
☐	☐	Do you have double or distorted vision?
☐	☐	Do you have difficulty with color vision?
☐	☐	Do you have difficulty with depth perception or difficulty going up and down stairs?
☐	☐	Are you unsatisfied with your vision?
☐	☐	Do you have difficulty driving? (seeing curbs, exits, traffic lights, road signs, etc.)
☐	☐	Do bright lights cause a decrease in vision? (sunny days, bright lights)
☐	☐	Does glare make driving difficult at night? (halos around lights, glare from car lights decrease your ability to see)
☐	☐	Do you have difficulty reading small print? (books, newspapers, reading time on your watch, medicine labels, etc.)
☐	☐	Do you have difficulty performing handiwork? (sewing, knitting, crochet, other fine tasks)
☐	☐	Do you have difficulty with personal correspondence? (writing checks, reading bills, doing forms)
☐	☐	Do you have difficulty with leisure activities? (playing cards, bingo, sports activities such as bowling, hunting, golf, tennis, fishing)
☐	☐	Do you have difficulty performing routine activities at home? (dialing the phone, cooking)
☐	☐	Are you unable to recognize the faces of people? (in church, stores, clubs)
☐	☐	Are you unable to care for yourself with your present vision? (do you live alone and wish to remain independent)
☐	☐	Do you have difficulty working on a computer?
☐	☐	Do you drive regularly at night?
☐	☐	Do you have hobbies that require very fine detailed vision?
☐	☐	Have you ever had refractive surgery? (RK, LASIK, PRK)

Signature of patient: ____