eye surgical associates

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CATARACT QUESTIONNAIRE

Patient Name: _____

Chart Number: _____

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

Reading small print, such as labels on medicine bottles, telephone books, or food labels:
☐ Yes ☐ No

Reading a newspaper or book?
☐ Yes ☐ No

Watching television?
☐ Yes ☐ No

Recognizing faces in the distance?
☐ Yes ☐ No

Seeing steps, stairs, or curbs?
☐ Yes ☐ No

Reading traffic signs, street signs, or store signs?
☐ Yes ☐ No

Doing fine handwork like sewing, knitting, crocheting, or carpentry?
☐ Yes ☐ No

Writing checks or filling out forms? Playing games such as bingo, dominoes, or card games?
☐ Yes ☐ No

Taking part in sports like bowling, handball, tennis, or golf?
☐ Yes ☐ No

Difficulty backing out of garage or driveway?
☐ Yes ☐ No

Judging distance objects are away from you?
☐ Yes ☐ No

Experience eyestrain with extended or detailed use of eyes?
☐ Yes ☐ No

Have you been bothered by:

Poor night vision?
☐ Yes ☐ No

Glare from headlights or the sun?
☐ Yes ☐ No

Rings, starbursts or halos around lights:
☐ Yes ☐ No

Poor color vision?
☐ Yes ☐ No

Double vision or ghost images?
☐ Yes ☐ No

Driving:

Have you ever driven a car?
☐ Yes (continue) ☐ No (Stop)

Do you currently drive a car?
☐ Yes (continue) ☐ No (Stop)

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

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

If you are no longer driving, when did you stop?

☐ 6 months ago ☐ 6 - 12 months ago ☐ More than 1 year ago

Patient Signature: _____ Date: _____

Reviewed:

Technician:				
Date:				