



1710 S. 70th Street
Lincoln, NE 68506
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PRE-YAG CAPSULOTOMY PATIENT QUESTIONNAIRE

Patient Name: _____
Chart Number: _____
Eye Being Evaluated <input type="checkbox"/> RT <input type="checkbox"/> LT

VISUAL FUNCTIONING

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

YES **NO**

- | | | |
|---|--------------------------|--------------------------|
| 1. Seeing clearly in bright lights (bright sunlight) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Seeing to drive at dusk or in the dark | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Recognizing people when they are close to you | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Reading traffic signs, street signs or store signs | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Doing fine handwork like sewing, knitting, crocheting or carpentry | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Watching television | <input type="checkbox"/> | <input type="checkbox"/> |

SYMPTOMS

Have you been bothered by:

YES **NO**

- | | | |
|---|--------------------------|--------------------------|
| 1. Poor night vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Seeing rings or halos around lights? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Glare caused by headlights or bright sunlight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Hazy and/or blurry vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Seeing well in poor or dim light? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Poor color vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Double vision? | <input type="checkbox"/> | <input type="checkbox"/> |

YAG laser capsulotomy can almost always be safely postponed until you feel you need better vision. If stronger glasses won't improve your vision any more, and if the only way to help you see better is YAG laser surgery, do you feel your vision problem is bad enough to consider laser surgery now?

Yes No

Patient Signature: _____ Date: _____