CATARACT QUESTIONNAIRE

Patient Name:_____ Chart #:_____

Have you noticed an increase in difficulty with the following:

Watching Television	YES ☐	NO ☐
Recognizing faces in the distance	YES ☐	NO ☐
Reading Traffic Signs or street signs	YES ☐	NO ☐
Depth Perception	YES ☐	NO ☐

Have you had changes in your close-up vision such as:

Reading the newspaper, medicine bottles or food labels	YES ☐	NO ☐
Writing checks or filling out forms	YES ☐	NO ☐
Fine handwork like knitting, sewing, card games	YES ☐	NO ☐

Has your vision affected you being able to perform your favorite activities or daily activities:

YES ☐ NO ☐

What type of activities do you enjoy? (circle all that apply)

Reading Golf Computer Board Games Other:_____

Has your vision been affected by any of the following?

Night vision, driving at night	YES ☐	NO ☐
Glare from headlights or sun	YES ☐	NO ☐
Rings, starbursts or halos around lights	YES ☐	NO ☐
Double vision or ghost images	YES ☐	NO ☐

Would you like more information about reducing your dependency for glasses?

YES ☐ ***NO*** ☐

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