Patient Questionnaire for Cataract Surgery

Patient Name: _____
Record No.: _____

What specific improvements in your activities or current restrictions in participation do you hope to gain with surgery?

_____

_____

Visual Functional Status *(Circle bracketed specifics as appropriate)*	**Circle**	
1) Do you have difficulty seeing street signs or seeing to drive? (curbs, freeway exits, traffic lights, halos/glare around light)	YES	NO
2) Do you have difficulty seeing TV or movies? (faces, numbers, or printing)	YES	NO
3) Do you have difficulty reading small print with good light, complete blinking and proper glasses? (books, newspapers, telephone books, medicine labels, instructions)	YES	NO
4) Do you have difficulty performing detailed work? (sewing, knitting, crocheting, embroidery, baiting a fish hook or other fine tasks)	YES	NO
5) Do you have difficulty with personal correspondences? (writing checks, reading bills, filling out forms)	YES	NO
6) Do you have difficulty with leisure activities such as sports or hobbies? (playing card games, bingo, dominoes, or activities such as bowling, hunting, golf, tennis, other_____)	YES	NO
7) Do you have visual difficulty functioning around the house? (cooking, ironing, general household upkeep, climbing steps/curbs, dialing a telephone, telling time on a watch, using public transportation)	YES	NO
8) Do you have difficulty recognizing faces of people? (in church, grocery store, clubs, and other daily activities)	YES	NO
9) If you live alone and wish to remain independent, are you unable to care for yourself with your present vision?	YES	NO

Do you have any of the following <u>VISUAL SYMPTOMS</u>?

1) Double or distorted vision?	YES	NO
2) Glare, halos, rings around lights?	YES	NO
3) Difficulty with color perception?	YES	NO
4) Difficulty with depth perception?	YES	NO
5) Worsening of vision — blurred vision?	YES	NO

Patient's Signature _____

Adapted from the form "Medical Necessity for Cataract Surgery" developed by the Texas Ophthalmological Association, with permission.