

Understanding your lifestyle and the activities you enjoy can help us recommend the kind of cataract surgery that will provide you with clearer vision and less dependence on glasses.

Name _____

What is (or was) your occupation? _____

Please check the following activities you do on a regular basis:



DISTANCE VISION

- | | |
|--|---|
| <input type="checkbox"/> Daytime Driving | <input type="checkbox"/> Watching Movies/Going to Theater |
| <input type="checkbox"/> Nighttime Driving | <input type="checkbox"/> Viewing Scenery/Taking Photographs |
| <input type="checkbox"/> Sports (golf, etc.) | <input type="checkbox"/> Other: _____ |



INTERMEDIATE VISION

- | | |
|---|--|
| <input type="checkbox"/> Seeing Car Dashboard | <input type="checkbox"/> Shopping |
| <input type="checkbox"/> Using Computer | <input type="checkbox"/> Playing Games (cards, etc.) |
| <input type="checkbox"/> Using Tablet | <input type="checkbox"/> Other: _____ |



NEAR VISION

- | | |
|--|--|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Needlework (sewing, etc.) |
| <input type="checkbox"/> Doing Crossword Puzzles | <input type="checkbox"/> Applying Makeup |
| <input type="checkbox"/> Using Cell Phone | <input type="checkbox"/> Other: _____ |

Are you having any difficulty with the following with your current vision?

- | | | |
|--|--|----------------------------------|
| <input type="checkbox"/> Bright Daylight | <input type="checkbox"/> Nighttime Streetlights/Headlights | <input type="checkbox"/> Reading |
|--|--|----------------------------------|

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LIFESTYLE QUESTIONS TELL US ABOUT YOU

AREA FOR OPTIONAL
LOGO TO BE ADDED
BY PRACTICE

Please place an "X" in the blue box on each row that best indicates how you feel about the following:

Correction of near vision: (e.g., reading, use of phone)	I want to wear glasses	I don't want to wear glasses
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Correction of intermediate vision: (e.g., using a tablet/computer)	I want to wear glasses	I don't want to wear glasses
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Correction of distance vision: (e.g., driving, watching television)	I want to wear glasses	I don't want to wear glasses
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Please indicate how knowledgeable you are about your cataract surgery options:

Not Knowledgeable Somewhat Knowledgeable Knowledgeable

Which of the following best describes your personality type?

Easygoing/Flexible Organized/Planner Perfectionist

Patient Signature

Date

