Cataract Surgery Pre-Op Questionnaire

Patient Name: _____ Date: _____

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

1. Reading small print, such as labels on medicine bottles or food labels?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the Activity
2. Reading a newspaper or book?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the Activity
3. Seeing steps, stairs, or curbs?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the Activity
4. Reading traffic, street, or store signs?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the Activity
5. Doing fine handwork, like sewing, knitting, crocheting, or carpentry?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the Activity
6. Writing checks or filling out forms?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the Activity
7. Playing games, such as bingo, dominos, or card games?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the Activity
8. Watching television?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the Activity

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Are you bothered by any of the following **symptoms**?

1. Hazy and/or blurry vision? Difficulty focusing?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the Activity
2. Poor night vision or difficulty seeing in dim light?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the Activity
3. Glare, halos, or streaks around lights?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the Activity
4. Glare from car headlights or bright sunlight?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the Activity
5. Always feeling like you need to clean your glasses?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the Activity

Patient Signature: _____ **Date: _____**