



Patient Name: \_\_\_\_\_

**Have you been bothered by:**

- |  |  |
|--|--|
| <input type="checkbox"/> Blurry Vision     | <input type="checkbox"/> seeing in poor or dim light         |
| <input type="checkbox"/> Hazy Vision       | <input type="checkbox"/> Halos                               |
| <input type="checkbox"/> Glare             | <input type="checkbox"/> Seeing rings or stars around lights |
| <input type="checkbox"/> Poor Night Vision | <input type="checkbox"/> Frequent changes in glasses         |

**Have you noticed difficulty with your vision when you:**

- |   |   |
|---|---|
| <input type="checkbox"/> Work at your job     | <input type="checkbox"/> Drive during daylight hours          |
| <input type="checkbox"/> Manage your home     | <input type="checkbox"/> Drive during the evening/night hours |
| <input type="checkbox"/> Watch TV             | <input type="checkbox"/> See traffic signs                    |
| <input type="checkbox"/> Get around your home | <input type="checkbox"/> Sew or do crafts                     |
| <input type="checkbox"/> Use a computer       | <input type="checkbox"/> Play golf                            |
| <input type="checkbox"/> Read Newspapers      | <input type="checkbox"/> Enjoy recreation or leisure          |
| <input type="checkbox"/> Read labels          | <input type="checkbox"/> Recognize people                     |
| <input type="checkbox"/> Read price tags      | <input type="checkbox"/> Other                                |
| <input type="checkbox"/> Shop for groceries   |   |

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Patient Name: \_\_\_\_\_

### Vision Lifestyle Survey

We want to help you maintain excellent vision. We will be evaluating you soon for cataracts. The term “cataracts” refers to a cloudy lens within the eye. When a cataract is removed, a lens implant is used to replace the cloudy natural lens. If it is determined that a lens implant is appropriate for you, your answers below will help in determining which implant best suits the demands of your lifestyle. Please fill this form out completely and bring it with you to your evaluation.

- 1. If lens replacement is recommended for you, please rate your vision preferences at the following distances:

**Distance Vision:** driving, golf, tennis, sports, watching TV

- Prefer no distance glasses
- I wouldn't mind wearing glasses for distance

**Mid-Range Vision:** computer, menus, price tags, cooking, board games

- Prefer no mid-range glasses
- I wouldn't mind mid-range glasses

**Near vision:** reading books and newspapers, doing detailed handiwork

- Prefer no near glasses
- I wouldn't mind near glasses

- 2. Please check the single statement that best describes you in terms of **night vision**:
  - Night vision is extremely important to me and I require the best possible quality.
  - I want to be able to drive comfortably at night but I would tolerate some light imperfections.
  - Night vision is not important to me
- 3. If you **had to wear glasses for one activity**, after surgery, which activity would you be most willing to wear glasses?
  - Distance Vision (driving, watching tv)
  - Mid-Range Vision (computer, dashboard)
  - Near Vision (reading, fine print)

- 4. If you could have good distance vision during the day without glasses and good near vision for reading without glasses, but the compromise was that you **might see some halos or rings around lights at night**, would that be okay?

YES or NO

- 5. If you could have good distance vision and mid-range vision during the day and night without glasses, but the compromise was that you **might need glasses for reading** fine print at near, would you like that option?

YES or NO

- 6. How many hours do you spend:

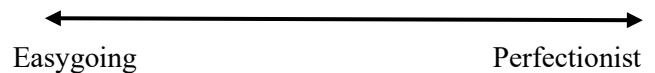
\_\_\_\_\_ on the computer?

\_\_\_\_\_ reading books, newspapers or small print?

\_\_\_\_\_ driving?

- 7. List your hobbies or work activities:

- 8. Place an x on the scale to describe you personality as best you can:



Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Pre-Operative Questions for Cataract Surgery

Patient Name: \_\_\_\_\_

1. Have you worn contacts within the **past two weeks**?    YES    or    NO

If yes: Soft contact lenses, please do NOT wear for two weeks **prior** to consult  
Hard contact lenses, please do NOT wear for 1 month **prior** to consult

2. Have you ever had eye surgery before?            YES    or    NO

(LASIK, PRK, RK, Corneal, Retinal, Strabismus etc.)

If yes, what type of eye surgery: \_\_\_\_\_

If you had LASIK was it for farsighted or nearsighted \_\_\_\_\_

3. Have you ever used any of the following medicines (even once) – Circle medicine(s)  
(Usually for prostate or urinary problems)

Flomax or Tamsulosin

Uroxatral or Alfuzosin

Cardura or Doxazosin

Rapaflo or Silodosin

Minipress or Prazosin

Proscar or Finasteride

Hytrin or Terazosin

Avodart or Dutasteride

Saw Palmetto

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_