



PRE-SURGICAL MEDICAL NECESSITY FOR CATARACT SURGERY PATIENT QUESTIONNAIRE

Date	Chart #		
Patient Name			
Reason for exam today (patient words)			
What specific improvements in your daily life do you hope to gain with surgery?			
Best corrected Snellen VA – Distance 20/ 20/	Near	Glare symptoms:	20/ 20/
<i>With blinking, good light and proper bifocal.</i>			

VISUAL FUNCTIONING

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

YES NO

- | | | |
|--|--------------------------|--------------------------|
| 1. Reading small print, such as labels on medicine bottles, telephone books, or food labels? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Reading a newspaper or book? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Reading a large-print book, or large-print newspaper, or large numbers on a telephone? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Recognizing people when they are close to you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Seeing steps, stairs or curbs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Reading traffic signs, street signs, or store signs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Doing fine handwork like sewing, knitting, crocheting, or carpentry? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Writing checks or filling out forms? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Playing games such as bingo, dominos, or card games? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Taking part in sports like bowling, handball, tennis, or golf? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Cooking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Watching television? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Are you able to care for yourself with your present vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you live alone and wish to remain independent? | <input type="checkbox"/> | <input type="checkbox"/> |

SYMPTOMS

Have you been bothered by:

YES

NO

- | | | |
|---|--------------------------|--------------------------|
| 1. Poor night vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Seeing rings or halos around lights? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Glare caused by headlights or bright sunlight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Hazy and/or blurry vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Seeing well in poor or dim light? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Poor color vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Double vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Distorted vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Difficulty with depth perception? | <input type="checkbox"/> | <input type="checkbox"/> |

DRIVING

- | | | |
|--|--|---|
| 1. Have you ever driven a car? | <input type="checkbox"/> YES (continue) | <input type="checkbox"/> NO (stop) |
| 2. Do you currently drive a car? | <input type="checkbox"/> YES (continue) | <input type="checkbox"/> NO (stop) |
| 3. How much difficulty do you have <u>driving during the day</u> because of your vision? | | |
| <input type="checkbox"/> No difficulty | <input type="checkbox"/> A moderate amount of difficulty | |
| <input type="checkbox"/> A little difficulty | <input type="checkbox"/> A great deal of difficulty | |
| 4. How much difficulty do you have <u>driving at night</u> because of your vision? | | |
| <input type="checkbox"/> No difficulty | <input type="checkbox"/> A moderate amount of difficulty | |
| <input type="checkbox"/> A little difficulty | <input type="checkbox"/> A great deal of difficulty | |
| 5. When did you stop driving? | | |
| <input type="checkbox"/> Less than 6 months ago | <input type="checkbox"/> 6-12 months ago | <input type="checkbox"/> More than 1 year ago |

Cataract surgery can almost always be safely postponed until you feel you need better vision. If stronger glasses won't improve your vision any more, and if the only way to help you see better is cataract surgery, do you feel your vision problem is bad enough to consider cataract surgery now?

YES **NO**

Patient Signature _____

Date _____