Huffman and Huffman –Eye Care Center, LLC

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Eye Physicians and Surgeons * Consultative Ophthalmology

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Pre-Surgical Cataract Patient Questionnaire

Patient Name: _____ DOB: _____

Visual Functioning

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___
2. Reading the newspaper or book? Yes___ No___
3. Reading a large print book or large print newspaper? Yes___ No___
4. Recognizing people even when they are close to you? Yes___ No___
5. Seeing steps, stairs or curbs? Yes___ No___
6. Reading traffic signs, street signs, interstate signs, and store signs? Yes___ No___
7. Doing fine handwork like sewing, knitting or carpentry? Yes___ No___
8. Writing checks or filling out forms? Yes___ No___
9. Playing games, such as bingo, dominos, or card games? Yes___ No___
10. Seeing to play sports/activities such as golfing, fishing, or hunting? Yes___ No___
11. Seeing to watch the television? Yes___ No___
12. Seeing to cook and bake? Yes___ No___

Symptoms

Have you been bothered by:

1. Poor night vision? Yes___ No___
2. Seeing rings or halos around lights? Yes___ No___
3. Glare caused by headlights, bright sunlight, or indoor lights? Yes___ No___
4. Hazy/blurry vision? Yes___ No___
5. Seeing well in poor or dim light? Yes___ No___
6. Poor color vision or issues distinguishing colors? Yes___ No___
7. Double vision? Yes___ No___

Driving

1. Have you ever driven a car? (If answer is yes, continue, skip if no) Yes___ No___
2. Do you currently drive a car? Yes___ No___
3. How much difficulty do you have driving during the day because of your vision?
    a. No difficulty
    b. A little difficulty
    c. A moderate amount of difficulty
    d. A great deal of difficulty
4. How much difficulty do you have driving during the night because of your vision?
    a. No difficulty
    b. A little difficulty
    c. A moderate amount of difficulty
    d. A great deal of difficulty
5. If you stopped driving, how long ago? _____

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

Yes _____ **No _____**

_____ Date: _____

Patient Signature

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Vision Preference Questionnaire

It is important to make sure your doctor has a complete understanding of your vision needs. These questions will help us recommend treatment options best suited for your unique lifestyle and preferences.

1. **What are some of your daily tasks and hobbies?** _____
_____

2. **What is your occupation? (if retired, write N/A)** _____

3. **Do you currently wear glasses?** Yes _____ No _____

4. **If yes, do you wear them for:** Near ____ Distance ____ All ____

5. **How enjoyable would it be for you to be glasses free for all of your daily activities?**

   Ecstatic _____ Very Nice _____ Okay _____ Insignificant _____

6. **Are you willing to pay out of pocket expenses, aside from what insurance will pay to reduce your dependence on glasses after cataract surgery?** Yes _____ No _____

____ Date: _______________

Patient Signature