Midwest Eye Professionals
OUR VISION IS YOUR VISION

Vision Preferences Checklist

Name _____ **Date** _____

We want to help you maintain excellent vision. One area of evaluation will be cataracts. The term "cataract" refers to a cloudy lens within the eye. When a cataract is removed, a lens implant is used to replace the cloudy human lens. If it is determined that a lens implant is appropriate for you, your answers will help us select an implant that best suits the vision demands of your lifestyle. Please fill this form out completely and return it to us.

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

Distance Vision: driving, golf, tennis, other sports, watching TV.

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

Mid-range Vision: computer, menus, price tags, cooking, board games, items on a shelf.

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

Near Vision: reading books, newspapers, magazines, doing detailed handwork.

- ☐ Prefer no near glasses
- ☐ I wouldn't mind wearing 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 slight imperfections.
- ☐ Night vision is not important to me.

3 If you **had to wear glasses after surgery for one activity**, for which activity would you be most willing to use glasses?

- ☐ Distance Vision
- ☐ Mid-range Vision
- ☐ Near Vision

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 OK?

- ☐ Yes
- ☐ 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** the finest print at near, would you like that option?

- ☐ Yes
- ☐ No

6 How many hours per day do you spend:

_____ **On the computer**

_____ **Reading** books, newspapers, typed documents or small print

_____ **Driving**

7 List your favorite **hobbies or work** activities.

8 Please place an "X" on the scale to **describe your personality** as best you can:

Easy going **Perfectionist**

Signature: _____

Pre-Surgical Cataract Patient Questionnaire

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TO BE FILLED OUT BY OFFICE

Patient Name: _____
Chart Number: _____
Eye Evaluated: ☐ OD ☐ OS

VISUAL FUNCTIONING

Do you have difficulties, even with glasses, with the following activities?	Yes	No
1. Reading small print, such as labels on medicine bottles, telephone books, or food labels?	☐	☐
2. Reading a newspaper or book?	☐	☐
3. Reading a large-print book, or large-print newspaper, or large number on a telephone book?	☐	☐
4. Recognizing people when they are close to you?	☐	☐
5. Seeing steps, stairs or curbs?	☐	☐
6. Reading traffic signs, street signs, or store signs?	☐	☐
7. Doing fine handwork like sewing, knitting, crocheting, or carpentry?	☐	☐
8. Writing checks or filling out forms?	☐	☐
9. Playing games such as bingo, dominos, or card games?	☐	☐
10. Taking part in sports like bowling, handball, tennis, or golf?	☐	☐
11. Cooking?	☐	☐
12. Watching television?	☐	☐

SYMPTOMS

Have you been bothered by?	Yes	No
1. Poor night vision?	☐	☐
2. Seeing rings or halos around lights?	☐	☐
3. Glare caused by head lights or bright sunlight?	☐	☐
4. Hazy and/or blurry vision?	☐	☐

SYMPTOMS *(continued)*

Have you been bothered by?	Yes	No
5. Seeing well in poor or dim lights?	☐	☐
6. Poor color vision?	☐	☐
7. Double vision?	☐	☐

Driving

1. Have you ever driven a car? ☐ **Yes** *(continue)* ☐ **No** *(stop)*

2. Do you currently drive a car? ☐ **Yes** *(continue)* ☐ **No** *(stop)*

3. How much difficulty do you have <u>driving during the day</u> because of your vision?

☐ No difficulty ☐ A moderate amount of difficulty

☐ A little difficulty ☐ A great deal of difficulty

4. How much difficulty do you have <u>driving at night</u> because of your vision?

☐ No difficulty ☐ A moderate amount of difficulty

☐ A little difficulty ☐ A great deal of difficulty

5. Have you stopped driving during the day or night or both because of your vision?

☐ Yes ☐ No

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:_____

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2.25D > Astigmastism > 1.00D Y N