LIFESTYLE QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

☐ Cataract ☐ Secondary Membrane ☐ Right Eye ☐ Left Eye

Do you have difficulty, **EVEN WITH GLASSES**, with the following activities? Please answer these questions pertaining to the eye with the worst vision, not both eyes seeing together.

1. Reading small print such as medicine bottle labels, a telephone book or texts on your cell phone?	☐ Yes ☐ No ☐ Not applicable
If yes, how much difficulty do you currently have?	☐ Little ☐ Moderate ☐ Great
2. Reading a newspaper, book, or restaurant menu?	☐ Yes ☐ No ☐ Not applicable
If yes, how much difficulty do you currently have?	☐ Little ☐ Moderate ☐ Great
3. Driving (nighttime, glares, halos, etc.)?	☐ Yes ☐ No ☐ Not applicable
If yes, how much difficulty do you currently have?	☐ Little ☐ Moderate ☐ Great
4. Reading traffic signs, street signs or store signs?	☐ Yes ☐ No ☐ Not applicable
If yes, how much difficulty do you currently have?	☐ Little ☐ Moderate ☐ Great
5. Performing hobbies (computer, crafts, sports, etc.)?	☐ Yes ☐ No ☐ Not applicable
If yes, how much difficulty do you currently have?	☐ Little ☐ Moderate ☐ Great
6. Writing checks or filling out forms?	☐ Yes ☐ No ☐ Not applicable
If yes, how much difficulty do you currently have?	☐ Little ☐ Moderate ☐ Great
7. Playing games such as bingo, dominos or crossword puzzles?	☐ Yes ☐ No ☐ Not applicable
If yes, how much difficulty do you currently have?	☐ Little ☐ Moderate ☐ Great
8. Watching television (TV guide, weather, sports, news scrolls)?	☐ Yes ☐ No ☐ Not applicable
If yes, how much difficulty do you currently have?	☐ Little ☐ Moderate ☐ Great

What is your desire to get rid of glasses: ☐ Totally ☐ Partially ☐ Don't care

What is most important to you: ☐ Close up vision ☐ Mid-range vision ☐ Distance vision

Patient Signature: _____ Date: _____