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EyeHub
Vision reimagined

Dr. Sonia Moorthy
Adult & Paediatric
Ophthalmic Surgeon
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LIFESTYLE VISION QUESTIONNAIRE

Name: _____ **Date:** _____

This questionnaire will assist us in providing a visual outcome more tailored to your lifestyle. In many cases, patients still need to wear glasses for some activities following cataract surgery.

Please complete this form and give it to your ophthalmologist and please let us know of any questions you may have.

Tell us about your current overall vision:

Q1 Do you wear glasses for any of the following:

- ☐ Reading the newspaper or mobile phone
- ☐ Driving, viewing street signs or watching television
- ☐ Using a computer / iPad or cooking

Q2 Would you like to reduce your dependence on glasses? Place an 'X' on the below scale.

0 — 5 — 10

I don't want to wear glasses ☐ — I'm happy wearing glasses ☐

Help us identify your visual range preference:

Q3 Which tasks do you do most often? Please number 1, 2 & 3 in order of preference:
(With "1" being the type of task you do most often.)

- ☐ ☐ Driving, watching sports events or at the c
- ☐ ☐ Watching television, using a computer or cooking. (Intermediate Vision)
- ☐ ☐ Reading fine print, fine handicrafts or sewing. (Near Vision)

Q4 Does your vision bother you at night? Place an 'X' on the below scale.

0 — 5 — 10

Frequently, such as difficulty driving at night ☐ — Sometimes ☐ — Seldom or not at all ☐

Tailoring vision to your natural lifestyle:

Q5 Indicate your personality by placing an 'X' on the below scale:

0 — 5 — 10

Perfectionist ☐ — Easy Going ☐

Q6 Share with us your occupation and any hobbies or activities that you take part in:

_____

_____

_____

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POST SURGERY QUESTIONNAIRE

Name: _____ **Date:** _____

Time since your operation: ☐ Less than 1 week ☐ 1 month ☐ 3 months ☐ 6 to 12 months ☐ Less than 2 years

Activities:

Q1 How would you rate your vision without glasses, for the below tasks?

Participating in physical or leisure activites
(Such as walking, playing sports, cooking or shopping)

0 — 5 — 10
Poor — Average — Good ☐

Watching movies or sport

0 — 5 — 10
Poor — Average — Good ☐

Using a computer

0 — 5 — 10
Poor — Average — Good ☐

Reading an iPad or smartphone

0 — 5 — 10
Poor — Average — Good ☐

Q2 How often do you require glasses for the below tasks?

Daytime driving (far distance)

0 — 5 — 10
Always — Sometimes — Never ☐

Nighttime driving (far distance)

0 — 5 — 10
Always — Sometimes — Never ☐

Computer use (intermediate distance)

0 — 5 — 10
Always — Sometimes — Never ☐

Reading or tasks that require near vision

0 — 5 — 10
Always — Sometimes — Never ☐

General Well Being:

Q3 Are you satisfied with the treatment result?
☐ No ☐ Yes

Q4 If given the choice, would you select the same treatment?
☐ No ☐ Yes

Q5 Would you recommend the treatment to a friend or relative?
☐ No ☐ Yes

Q6 How is your visual acuity at night?
☐ Worse ☐ Equal ☐ Better

Q7 Do you experience halos or starbursts around lights?
☐ No ☐ Yes (Please rate you experience below.)

0 — 5 — 10
Very bothersome — Not at all bothersome ☐

Q8 Do you experience glare or sensitivity to bright lights?
☐ No ☐ Yes (Please rate you experience below.)

0 — 5 — 10
Very bothersome — Not at all bothersome ☐

Sign _____

Submit

Email _____