

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.

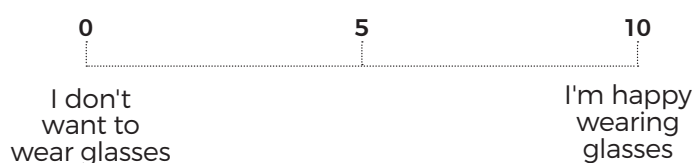
Please complete this form and give it to your ophthalmologist and please let us know of any questions you may have.

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.



Help us identify your visual range preference:

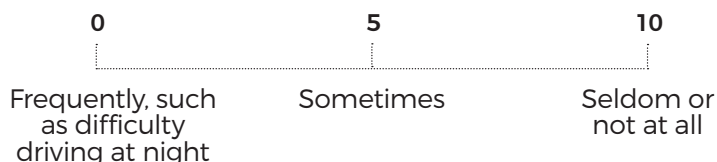
Q3 Which tasks do you do most often?
Please number 1, 2 & 3 in order of preference:
(With "1" being the type of task you do most often.)

Driving, watching sports events or at the c

Watching television, using a computer or cooking. (Intermediate Vision)

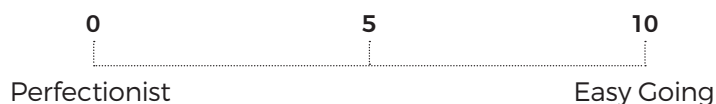
Reading fine print, fine handicrafts or sewing. (Near Vision)

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



Tailoring vision to your natural lifestyle:

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



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

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 activities
(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

Q5 Would you recommend the treatment to a friend or relative?

☐ No ☐ Yes

Q7 Do you experience halos or starbursts around lights?

☐ No ☐ Yes (Please rate your experience below.)

0 5 10
 Very bothersome Not at all bothersome

Q4 If given the choice, would you select the same treatment?

☐ No ☐ Yes

Q6 How is your visual acuity at night?

☐ Worse ☐ Equal ☐ Better

Q8 Do you experience glare or sensitivity to bright lights?

☐ No ☐ Yes (Please rate your experience below.)

0 5 10
 Very bothersome Not at all bothersome