Pre-Operative Cataract / YAG Questionnaire

Name: _____ DOB: _____/_____/_____

Visual Functioning

Do you have difficulty, even with glasses, doing the following activities?	**Right Eye**		**Left Eye**	
1. Reading small print, such as telephone books or medicine bottles?	Yes	No	Yes	No
2. Reading books or news paper print?	Yes	No	Yes	No
3. Reading large print books?	Yes	No	Yes	No
4. Reading traffic signs or street signs?	Yes	No	Yes	No
5. Watching television, playing cards, or playing sports?	Yes	No	Yes	No
6. Seeing steps, stairs, or curbs?	Yes	No	Yes	No

Symptoms

Are you bothered by?	**Right Eye**		**Left Eye**	
1. Poor night vision?	Yes	No	Yes	No
2. Seeing halos around lights?	Yes	No	Yes	No
3. Glare caused by headlights or bright lights?	Yes	No	Yes	No
4. Poor color vision?	Yes	No	Yes	No
5. Hazy or blurred vision?	Yes	No	Yes	No
6. Double vision?	Yes	No	Yes	No

How much difficulty do you have driving during the DAY because of your vision?

A great deal Moderate A little None

How much difficulty do you have driving at NIGHT because of your vision?

A great deal Moderate A little None

Have you ever had LASIK (Laser Vision Correction)? Yes When? _____ Or No

Patient Signature: _____ Date: _____/_____/_____

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