ecva EYECARE

Cataract Patient Questionnaire

This questionnaire is to help your doctor know how your cataracts are affecting your vision and your daily life. Please check the statements that apply to you with a Yes or No. If Yes please indicate the appropriate eye(s).

Yes No

_____ _____ **I need to drive, but there is too much glare from the sun or headlights.**
❑ Right Eye ❑ Left Eye ❑ Both Eyes

_____ _____ **I do not see well enough to do my best at work, difficulty seeing computer.**
❑ Right Eye ❑ Left Eye ❑ Both Eyes

_____ _____ **I do not see well enough to do the things I need to do at home.**
❑ Right Eye ❑ Left Eye ❑ Both Eyes

_____ _____ **I do not see well enough to watch T.V.**
❑ Right Eye ❑ Left Eye ❑ Both Eyes

_____ _____ **I do not see well enough to read.**
(example: medicine bottles, food labels, books, recipes).
❑ Right Eye ❑ Left Eye ❑ Both Eyes

_____ _____ **I do not see well enough to do things I like to do like**
(example: sewing, playing cards, shopping, sports or going with friends).
❑ Right Eye ❑ Left Eye ❑ Both Eyes

_____ _____ **I feel unsteady and I don't feel safe due to my poor vision.**
❑ Right Eye ❑ Left Eye ❑ Both Eyes

_____ _____ **Because of my cataract, I am not as independent as I would like to be.**
❑ Right Eye ❑ Left Eye ❑ Both Eyes

_____ _____ **My eyeglasses do not help me see well enough.**
❑ Right Eye ❑ Left Eye ❑ Both Eyes

Patient/Relative/Guardian	**Print Name**	**Date/Time**
Physician's Signature	**Print Name**	**Date/Time**