Pt. Name_____ Date_____

Quality of Vision Check List

This check list will assist us in providing the treatment best suited for your visual needs if it is determined that cataract surgery is appropriate for you. It is important that you understand that many patients still need to wear glasses for some activities after surgery but due to recent technological advances, we are now able to offer the possibility for you to be potentially free from glasses. Please fill this form out completely and return it to us. If you have questions, please let us know and we will be happy to assist you.

- Are you interested in seeing well at distance without glasses after surgery?
  _____ I prefer no distance glasses.

  _____ Not important to me. I wouldn't mind wearing distance glasses.

- Are you interested in seeing well at near without glasses after surgery?
  _____ I prefer no reading glasses

  _____ Not important to me. I wouldn't mind wearing reading glasses.

Zone 1	Zone 2	Zone 3
Reading-Phonebook	Shaving	Watching TV
Sewing	Computer-emailing	Driving
Applying Make-up	Cooking	Watching Movies
Working Crossword puzzles	Reading Labels on Shelf	Golfing

- Which "Zone of Vision" is most important to you? Please choose only one of the following three options?
  _____ Zone 1 _____ Zone 2 _____Zone 3

- If you had to wear glasses after surgery for one zone, for which zone would you be most willing to use glasses?
  _____ Zone 1 _____ Zone 2 _____Zone 3

Would you be willing to give up some sharpness to your vision in order to be free from glasses for most daily activities?_____

If you could have good distance vision during the day without glasses, and good near vision for reading without glasses, but the compromise was that you might see some halos around lights at night, would you like that option? YES_____ NO_____

Are you the type of person that a mild film over your windshield would bother you?_____

Please place an "X" on the following scale to describe your personality as best you can:

Easy going ←——————————————————→ Perfectionist

Patient Signature: _____