

Advanced Glaucoma Specialists

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Ophthalmology

CATARACT & REFRACTIVE LENS EXCHANGE QUESTIONNAIRE

Name: _____

Date: ____/____/____

It is important to make sure your doctor has a complete understanding of your vision needs. This questionnaire will help us recommend treatment options best suited to your unique lifestyle and preferences.

What is your occupation? _____

What hobbies, sports or other recreational activities do you enjoy?

Please circle the activities you would prefer to do with less dependence on glasses:

Reading books/newspapers

Applying makeup

Watching live sports

Reading medicine labels

Shaving your face

Playing sports, like golf

Looking at your watch

Card or table games

Watching TV

Viewing/dialing cell phone

Using a computer

Daytime driving

Knitting or needlepoint

Using a handheld tablet device

Nighttime driving

Other activities not listed here: _____

Please share anything else you think might be important about your lifestyle or daily activities: _____

Patient Signature: _____

Staff initials: _____ Physician initials: _____