Questionnaire

Advance Glaucoma Specialists
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Opthalmology

Cataract & Refractive Lens Exchange Questionnaire

Patient 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?

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

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Please check 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:

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Patient Signature: ____

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Staff Initials: ______________ Physician Initials: ______________