Cataract, Glaucoma & Retina
CONSULTANTS OF EAST TEXAS
Medical Arts Surgery Center | Benchmark Optical

VISION QUESTIONNAIRE

PATIENT'S NAME OR ID: ______________________________ **DATE:** ________________

- **How important is it for you to see to read without glasses after surgery?**

  ☐ Very Important ☐ Important ☐ Somewhat Important ☐ Not Important

  How many hours per day do you read? ____________________

- **Do you use a computer?**

  If yes, how many hours per day? __________

- **Do you drive at night?** (Check all that apply)

  ☐ Socially ☐ Occasionally ☐ As Profession

- **What are your favorite hobbies?**

  ____

  ____

  ____

- **Which of the following activities would you like to be able to do *without* glasses?** (Check all that apply)

  ☐ Reading newspapers or medicine bottles up close (less than 12 inches from face)

  ☐ Computer, playing piano or reading music, painting on easel, cooking,
  Reading menus (12- 24 inches or more from face)

  ☐ Driving, sightseeing, movies, golf, fish, hunt, tennis, artist

- **What sporting or recreational activities do you currently engage in?**

  ____

  ____

  ____

- **Please tell us about any vision concerns that are not addressed above:**

  ____

  ____

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  ____

- **Would you like to know about options after surgery to be less dependent on glasses based upon your lifestyle?**

  ☐ Yes ☐ No

- **Using the scale below, select a number that best describes your personality:**

1	2	3	4	5
○	○	○	○	○
Easy Going		Balanced		Perfectionist

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