Refractive Cataract Surgery Patient Questionnaire

Patient Name:	Date:
Date of Birth:	*CEA Chart #*

Referring Doctor Information		
Last Name:	First:	Middle:
Office Mailing Address		
City:	State:	Zip Code:
Office Telephone: ( )	UPIN #:	
Doctor's Signature:		
Name of Doctor Patient to See:		

Are you interested in learning more about being less dependent on glasses after surgery? (circle) YES NO

How many years old are your current glasses?

Primary Pair:_____ Sunglasses:_____ Reading Glasses: _____
Computer Glasses:_____ Sports Glasses:_____ Occupational Glasses: _____

Do you drive after dark? (circle)	OFTEN	SOMETIMES	RARELY/NEVER
Do you use a computer? (circle)	OFTEN	SOMETIMES	RARELY/NEVER
Do you do a lot of close detail work, like sewing or building models? (circle)	OFTEN	SOMETIMES	RARELY/NEVER

Have you ever tried mono-vision contact lenses (one eye near, one eye distance)? YES NO

Have you ever had LASIK or RK? YES NO **If Yes,** date of surgery_____

Continued on back

How important is it for you to be free of glasses for the following activities……	**None←→Severe**					
Seeing computer screen	N/A	0	1	2	3	4
Driving	N/A	0	1	2	3	4
Vision for sports (following golf ball, tennis ball)	N/A	0	1	2	3	4
Hobbies requiring fine vision (sewing, carpentry)	N/A	0	1	2	3	4
Playing games like cards, bingo, etc.	N/A	0	1	2	3	4
Seeing small captions on the TV	N/A	0	1	2	3	4
Reading fine print (medicine bottles, telephone book, food labels)	N/A	0	1	2	3	4

If you **had** to wear glasses after surgery for one activity, for which activity would you be **most willing** to wear glasses? **____Reading fine print** **____Computer** **____Driving**

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

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Easy Going Perfectionist

_____

Patient Signature Date

Continued on back