HOUSTON LASIK & EYE

Lens Lifestyle Questionnaire

We recognize that your eyes are very important to you. Along with your eye exam, this info will assist us in recommending the best options for your eyes.

Occupation: _____ Hobbies: _____

1. After surgery, would you be interested in seeing well without glasses in the following situations?

Distance vision (driving, walking, tennis, watching TV)

❍Prefer no Distance glasses. ❍Not important. I wouldn't mind wearing Distance glasses.

Mid-range vision (computer, menus, price tags, cooking, board games, items on a shelf)

❍Prefer no Mid-range glasses. ❍Not important. I wouldn't mind wearing Mid-range glasses.

Near vision (reading books, newspapers, magazine, sewing)

❍Prefer no Near glasses. ❍Not important. I wouldn't mind wearing Near glasses.

2. Please check the **single** statement that best describes you in terms of night vision

❍ Night vision is extremely important to me, and I require the best possible quality night vision.
❍ I want to be able to drive comfortably at night, but I would tolerate some slight imperfections.
❍ Night vision is not particularly important to me.

3. If you had to wear glasses after surgery for one activity, for which activity would you be most willing to use glasses?

❍Distance vision (driving) ❍Mid-range vision (computer) ❍Near vision (reading)

4. If you could have good vision for driving during the day without glasses, and good near vision without glasses in most situations, would you be able to tolerate some halos and glare around lights at night?

❍ Yes ❍ No

5. If you could have good distance vision day and night, and good vision for computer work, without glasses, would you be willing to wear glasses for reading fine print and small type?

❍ Yes ❍ No

Please place an "X" on the following scale to describe your motivation to reduce dependence on glasses:

|----------|----------|

Prefer glasses at all times	Somewhat interested	I hate glasses!

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

|----------|----------|

Easy going	Perfectionist

Patient Signature: _____ Date: _____

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MEDICAL NECESSITY FOR CATARACT SURGERY

Reason for exam (patient's words): _____
What specific improvements in your daily life do you hope to gain with surgery? _____
_____

Visual Functional Status (complete all lines by circling YES or NO)

YES NO Do you have difficulty seeing street signs or driving? (Curbs, freeway exits, traffic lights, halos/glare around lights)

YES NO Do you have difficulty seeing TV of movies? (Faces, numbers, or printing)

YES NO Do you have difficulty reading small print with good light, blinking, and proper glasses? (Books, newspaper, telephone book, medicine labels, instructions)

YES NO Do you have difficult performing detailed work? (Sewing, knitting, crocheting, embroidery, baiting a fish hook, or other fine task)

YES NO Do you difficulty with personal correspondences? (Writing checks, reading bills, filling out forms)

YES NO Do you difficult with leisure activities such as sports or hobbies? (Playing card games, bingo, dominoes, or sport activities such as bowling, hunting, golf, tennis, other _____)

YES NO Do you have visual difficulty functioning around the house? (Cooking, ironing, general household upkeep, climbing steps or curbs, dialing the telephone, telling time on a watch, using public transportation

YES NO Are you unable to see and recognize faces of other people? (In church, grocery store, clubs, and other daily activities

YES NO If you live alone and wish to remain independent, are you unable to care for yourself with your present vision?

Do you have any of the following <u>VISUAL SYMPTOMS</u>

YES NO Double or distorted vision?

YES NO Glare, halos, rings around lights

YES NO Difficulty with color perception

YES NO Difficulty with depth perception? Worsening of vision – blurred vision?

Right Left Which eye are you describing?

Patient Signature: _____ Date: _____