Print Name:_____ Date:_____/_____/_____

Vision Preference Questionnaire:

If undergoing cataract surgery, this questionnaire will help us provide the treatment best suited to your visual needs. It is important to understand many patients still need to wear glasses for some activities after surgery. Due to recent technological advances, we are now able to offer the possibility for you to be potentially free from glasses. If you have questions, please let us know and we will be happy to assist you.

1. Would you like to be free from glasses at distance vision?

☐ I'd rather not wear glasses for distance vision ☐ I wouldn't mind wearing glasses for distance vision

2. Would you like to see up close without glasses?

☐ I'd rather not wear glasses for near vision ☐ I don't mind wearing reading glasses

ZONE 1	ZONE 2	ZONE 3
Cell Phone Usage Reading Applying Make-Up Shaving Reading Medicine Labels Sewing/Needlepoint Working Crossword Puzzles	Cooking Car Dashboard Emailing/Computer Reading Labels on Shelf	Driving Watching TV Sightseeing Golfing /Sports Watching Movie/Theatre

3. Which "Zone of Vision" is most important to you? Please choose only one.

☐ Zone 1 ☐ Zone 2 ☐ Zone 3

4. If you had to wear glasses after surgery for one zone, which would it be?

☐ Zone 1 ☐ Zone 2 ☐ Zone 3

5. How important is it to you to be able to read in low-light situations (such as reading at night and restaurant lighting) without the use of glasses?

☐ Very important ☐ Moderately important ☐ Not important

6. Overall, how important is it to be free from glasses for your daily activities?

☐ Very important ☐ Moderately important ☐ Not important

7. Place an "X" on the following scale to describe your personality as best you can:

_____

Easy Going Perfectionist

8. At what age did you begin wearing glasses? _____

Patient Signature: _____ Date:_____

For Office Use Only:

Discussed Recommends Signed by: