

**Patients Name:** \_\_\_\_\_ **Practice:** Eye  
Consultants, P.C.

**Operating Physician: (Circle One):** Dr. Joseph Townley Dr. Thomas Hejkal

**Medicare Number / ID#:** \_\_\_\_\_

**Surgery Date(s):** \_\_\_\_\_

### Pre- Cataract Surgery – Visual Functioning Patient Questionnaire

Do you have difficulty, even with glasses with the following activities?

1. Reading small print such as labels on medicine bottles, or food labels?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little <input type="checkbox"/> A Moderate Amount <input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity
2. Reading a newspaper or book?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little <input type="checkbox"/> A Moderate Amount <input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity
3. Seeing steps, stairs, or curbs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little <input type="checkbox"/> A Moderate Amount <input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity
4. Reading traffic signs, street signs, or store signs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little <input type="checkbox"/> A Moderate Amount <input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity
5. Doing fine handwork like sewing, knitting, or carpentry?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little <input type="checkbox"/> A Moderate Amount <input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity
6. Writing checks or filling out forms?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little <input type="checkbox"/> A Moderate Amount <input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity
7. Playing games such as bingo, dominos, card games, or mahjong?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little <input type="checkbox"/> A Moderate Amount <input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity
8. Watching television?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little <input type="checkbox"/> A Moderate Amount <input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity

**Patient Signature:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_