Cataract Surgery Lifestyle Questionnaire

Patient Name: _____

Date of Birth: _____

Consultation Date: _____

What are your main concerns about your vision currently? (Check all that apply)

☐ Blurry vision
☐ Glare or halos at night
☐ Difficulty reading
☐ Trouble with driving
☐ Difficulty with computer work
☐ Other: _____

How would you rate your current satisfaction with your vision?

☐ Very satisfied
☐ Somewhat satisfied
☐ Neutral
☐ Somewhat dissatisfied
☐ Very dissatisfied

Do you currently wear glasses or contact lenses?

☐ Glasses (Distance)
☐ Glasses (Reading)
☐ Bifocals/Progressives
☐ Contact lenses
☐ None

Are you hoping to reduce your dependence on glasses after cataract surgery?

☐ Yes – for all distances
☐ Yes – mainly for reading
☐ Yes – mainly for distance
☐ No – I don't mind wearing glasses

Have you ever worn monovision correction?
(one eye corrected for distance, the other for near)

☐ Yes ☐ No ☐ Not sure

Are you currently employed?

☐ No
☐ Yes – Occupation: _____

Please list any hobbies or regular activities that require specific vision
(e.g., golf, knitting, painting, night driving, etc.):

_____

_____

How often do you engage in the following activities? (Check one per row)

Activity	Never	Occasionally	Frequently	Daily
Reading books or newspapers	☐	☐	☐	☐
Using a computer or tablet	☐	☐	☐	☐
Driving during the day	☐	☐	☐	☐
Driving at night	☐	☐	☐	☐
Watching television	☐	☐	☐	☐
Playing sports/outdoor activities	☐	☐	☐	☐
Reading labels or small print	☐	☐	☐	☐

How bothered would you be by a small amount of glare?
(This would likely be less than what you currently experience.)
☐ Very Bothered ☐ Somewhat Bothered ☐ Not at All Bothered

How would you describe your visual expectations following cataract surgery?

☐ Basic Vision: I want to clear my cloudy vision and understand I will likely need glasses for both distance and near tasks.

☐ Visual Independence: I want to minimize my reliance on glasses for most daily tasks and am interested in customized options that may involve out-of-pocket costs.

Please place an "X" on the following scale to describe your personality:
(This helps us understand how you might adapt to different vision correction options.)

Easy going ---------- *Perfectionist*

Is there anything else you would like your surgeon to know about your lifestyle or vision needs?
(Use this space to share any other goals, preferences, or concerns.)