Patient Name______________________ Date__________

QUESTIONS ABOUT YOUR FUNCTIONAL VISION THAT CAN BE AFFECTED BY CATARACTS

Do you have any difficulty, even with glasses:

	YES	NO	N/A
1. Reading small print, such as labels on medicine bottles, a telephone book or food labels?	☐	☐	☐
2. Reading a newspaper or a book?	☐	☐	☐
3. Reading a large-print book, large-print newspaper or numbers on a phone?	☐	☐	☐
4. Recognizing people when they are close to you?	☐	☐	☐
5. Seeing steps, stairs or curbs?	☐	☐	☐
6. Reading traffic signs, street signs or store signs?	☐	☐	☐
7. Doing fine handwork like sewing, knitting, crocheting or carpentry?	☐	☐	☐
8. Playing games such as bingo, dominoes or card games?	☐	☐	☐
9. Writing checks or filling out forms?	☐	☐	☐
10. Taking part in sports such as bowling, handball, tennis or golf?	☐	☐	☐
11. Cooking?	☐	☐	☐
12. Watching television?	☐	☐	☐
13. Do you currently drive a car?	☐	☐	☐
If yes:			
A. Do you have difficulty driving during the day because of your vision?	☐	☐	☐
B. Do you have difficulty driving at night because of your vision?	☐	☐	☐

Signature:______________________ Dated:______________