



Name: _____

Date: _____

VISION PREFERENCE CHECKLIST

This checklist will assist us in providing the treatment best suited for your visual needs if it is determined that cataract surgery or refractive lens exchange is appropriate for you. It is important that you understand that many patients will need to wear glasses for some activities after surgery, but due to recent technological advances, we are now able to offer the possibility for you to be potentially free from glasses. Please fill this form out completely and return it to us. If you have any questions, please let us know and we will be happy to assist you.

1. Are you interested in seeing well at a distance without glasses, (driving, playing golf, watching TV)?
_____ I prefer no distance glasses.

_____ I wouldn't mind wearing glasses. It is not important to me.
2. Are you interested in seeing well at near without glasses (reading books, newspapers, detailed handwork.)?
_____ I prefer no reading glasses.

_____ I wouldn't mind reading glasses. It is not important to me.
3. If you had to wear glasses after surgery, for which activity would you be most willing to use glasses? Check one:
_____ Reading a book, shaving, applying make-up, sewing (near vision).

_____ Computer, menus, board games, items on shelf (mid vision).

_____ Watching TV, driving, golf, tennis (distance vision).
4. If you could have good vision at near, as well as distance, without glasses, but the compromise was that you might see some halos around lights at night, would you be interested in that option?
_____ YES _____ NO
5. Do you drive regularly at night? _____ YES _____ NO
6. What are your hobbies: _____
7. How many hours per day do you spend:
_____ On a computer?
_____ Reading books, newspapers, or doing handwork?
_____ Driving, watching TV, playing sports?