

**VISION QUESTIONNAIRE**

1. Who **referred** you to us, or how did you find out about us? \_\_\_\_\_

2. Who is your **regular eye doctor**? \_\_\_\_\_

3. Briefly, **how** does your **vision bother** you the **most**? \_\_\_\_\_

4. Does your vision affect your **activities of daily living**?.....  Yes ..  No

5. Are you **bothered** at times by **glare** from bright lights or the sun? .....  Yes ..  No

6. Do you see **halos** around headlights or streetlights when night-driving?.....  Yes ..  No

7. Have you ever had **eye surgery** (including refractive surgery, LASIK, PRK, RK)?.....  Yes ...  No

Surgery	Eye (R/L)	Date	Location	Surgeon

8. Have you ever had a significant **eye injury**? .....  Yes ...  No  
 If “Yes”, when, and details? \_\_\_\_\_

9. List all of the **medications** you take for your eyes (drops, pills, supplements)

Medication	Eye (R/L)	Dosage Frequency	Taken Since When	Prescribing Doctor

10. Would you like to **reduce your need for glasses** after cataract surgery?.....  Yes ....  No

11. Which is your **dominant eye**? (for shooting or taking a picture)       Right..  Left.    Not Sure

12. What is your **occupation**? \_\_\_\_\_ ( Retired; what was your occupation?)

13. What is your main **hobby**? \_\_\_\_\_

Patient’s Signature: X \_\_\_\_\_ Date: \_\_\_\_\_