Vision Questionnaire

Please complete and bring with you to the office!

1. Who **referred** you to Dr. Davidson, or how did you find out about us? _____
2. Please list your **regular eye doctor(s)**_____
3. Briefly, **how** does your **vision bother** you the **most**?_____
4. Does your vision affect your **activities of daily living** (reading, driving, TV, PC)? .....□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, tears) ……..□None

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

10. Would you like to **see well without 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:_____