Martinelli Eye and Laser Centers Pre-Surgical Cataract Patient Questionnaire

Patient:	Eye being Evaluated:	Right	Left			
VISUAL FUNCTIONING: Do you have difficulty, even with glasses, with the following activities:						
1. Reading small print, such as labels books, or food labels?	on medicine bottles, telephone	YES	NO			
2. Reading a newspaper or book?		YES	NO			
3. Reading a large-print book, or a large numbers on a telephone?	ge-print newspaper, or large	YES	NO			
4. Recognizing people when they are	close to you?	YES	NO			
5. Seeing steps, stairs, or curbs?		YES	NO			
6. Reading traffic signs, street signs, o	or store signs?	YES	NO			
7. Doing fine handwork like sewing, l	knitting, crocheting, or carpentry	? YES	NO			
8. Writing checks or filling out forms	?	YES	NO			
9. Playing games such as bingo, domi	nos, or card games?	YES	NO			
10. Taking part in sports like bowling,	handball, tennis, or golf?	YES	NO			
11. Cooking?		YES	NO			
12. Watching television?		YES	NO			
SYMPTOMS: Have you been bothered by:						
1. Poor night vision?		YES	NO			
2. Seeing rays or halos around lights?		YES	NO			
3. Glare caused by headlights or brigh	t sunlight?	YES	NO			
4. Hazy and/or blurry vision?		YES	NO			
5. Seeing well in poor or dim light?		YES	NO			
6. Poor color vision?		YES	NO			

Pat	tient Signature		Date
vis hel	ion. If stronger glasses won	't improv	afely postponed until you feel you need better we your vision any more, and if the only way to o you feel your vision problem is bad enough t
	nen did you stop driving?Less than 6 months ago6-12 monthsMore than 1 year ago		
	w much difficulty do you haNo difficultyA little difficultyA moderate amount of diffA great deal of difficulty		ng at night because of your vision?
	w much difficulty do you haNo difficultyA little difficultyA moderate amount of diffA great deal of difficulty		ng during the day because of your vision?
2. Do	you currently drive a car?	YES	NO
l. Ha	ve you ever driven a car?	YES	NO