



EYE CONSULTANTS, P.C.

Patients Name: _____ **Practice:** Eye Consultants, P.C.

Operating Physician: (Circle One): Dr. Joseph Townley Dr. Michael daSilva Dr. Shane Havens

Medicare Number/ ID #: _____ **Surgery Date(s):** _____

Pre-Cataract Surgery – Visual Functioning Patient Questionnaire

Do you have difficulty, even with glasses with the following activities?	1 Not At All	2 A Little	3 A Moderate Amount	4 A Great Deal	5 Unable to do Activity
1) Reading small print such as labels on medicine bottles or food labels?					
2) Reading a newspaper or book?					
3) Reading a large print newspaper or book? Or reading numbers on a telephone?					
4) Writing checks or filling out forms?					
5) Recognizing people or faces when they're close to you?					
6) Seeing steps, stairs, or curbs? Or having difficulties with depth perception?					
7) Reading traffic signs, street signs, airport signs, or other distance vision difficulties?					
8) Handiwork such as knitting, sewing, crocheting, or carpentry?					
9) Playing games such as bingo, mahjong, dominos, or card games?					
10) Cooking?					
11) Watching TV?					
12) Driving during the day?					
13) Driving at night?					
14) Difficulties with glare, halos, or night vision?					

Patient Signature: _____ **Today's Date:** _____