OPHTHALMIC CONSULTANTS OF VERMONT
VERMONT LASER VISION
VERMONT COSMETIC EYE

CATARACT/REFRACTIVE QUESTIONNAIRE & VISUAL ASSESSMENT

PATIENT NAME: _____ DATE: _____/_____/_____

A "cataract" is the progressive cloudiness of the natural lens within the eye. The surgeon replaces the cloudy lens with an intraocular lens implant (IOL). If surgery is appropriate for you, this questionnaire will help us provide the best IOL for your visual needs. It is important to understand that many patients still need glasses for some activities after surgery. Please fill this form out completely. **This form is intended to get you thinking about your post-operative goals. You will receive additional education during the visit when the doctor discusses lens options with you.**

1. AFTER SURGERY, WOULD YOU BE INTERESTED IN SEEING WELL WITHOUT GLASSES IN THE FOLLOWING SITUATIONS?

	I'D PREFER...	
DISTANCE VISION (driving, golf, tennis, other sports, watching tv)	□ NO **DISTANCE** GLASSES	□ I wouldn't mind
MID-RANGE VISION (computer, menus, price tags, cooking, board games, items on a shelf)	□ NO **MID-RANGE** GLASSES	□ I wouldn't mind
NEAR VISION (reading books, smartphones, tablets, e-readers, sewing, detailed handwork)	□ NO **NEAR** GLASSES	□ I wouldn't mind

2. PLEASE CHECK THE SINGLE STATEMENT THAT BEST DESCRIBES YOU IN TERMS OF NIGHT VISION:
   - □ Night vision is extremely important to me and I require the best possible quality night vision
   - □ I want to be able to drive comfortably at night, but I would tolerate some slight imperfections
   - □ Night vision is not particularly important to me

3. IF YOU HAD TO WEAR GLASSES AFTER SURGERY FOR ONE ACTIVITY, FOR WHICH ACTIVITY WOULD YOU BE MOST WILLING TO USE GLASSES?
   □ **DISTANCE** VISION □ **MID-RANGE** VISION □ **NEAR** VISION

4. IF YOU COULD HAVE GOOD DISTANCE AND MID-RANGE VISION (WITHOUT GLASSES), BUT THE COMPROMISE WAS THAT YOU WOULD LIKELY SEE HALOS, RINGS OR STARBURSTS AROUND LIGHTS AT NIGHT, WOULD YOU LIKE THAT OPTION?
   □ **YES** □ **NO**

5. IF YOU COULD HAVE GOOD DISTANCE AND MID-RANGE VISION (WITHOUT GLASSES), BUT THE COMPROMISE WAS THAT YOU MIGHT NEED GLASSES FOR NEAR WITH MILD HALOS, RINGS OR STARBURSTS AROUND LIGHTS AT NIGHT, WOULD YOU LIKE THAT OPTION?
   □ **YES** □ **NO**

6. SOME LENS IMPLANTS THAT ARE DESIGNED TO REDUCE THE NEED FOR GLASSES AFTER CATARACT SURGERY ARE NOT COVERED BY INSURANCE. THE ADDITIONAL COST RANGES FROM **$1,400 - $3,900** PER EYE. IF YOU ARE A CANDIDATE, WOULD YOU BE INTERESTED?
   □ **YES** □ **NO** (I don't mind glasses)

7. WHICH STATEMENT BEST DESCRIBES YOU?
   - □ I would prefer not to wear glasses for distance, but I don't mind wearing them for reading
   - □ I would prefer not to wear glasses for reading, but I don't mind wearing them for distance
   - □ I do not want to wear glasses and would be willing to accept halos, rings or starbursts around lights to reduce my need for glasses at all distances
   - □ I would like good distance vision and would be willing to accept mild halos, rings or starbursts if I could also have good mid-range vision

8. PLEASE PLACE AN "**X**" ON THE FOLLOWING SCALE TO DESCRIBE YOUR PERSONALITY THE BEST YOU CAN:

|_____|_____|

EASY GOING PERFECTIONIST

THIS DOCUMENT IS DOUBLE SIDED →

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VISUAL FUNCTIONING -
EVEN WITH CORRECTIVE GLASSES OR CONTACT LENSES, I HAVE TROUBLE WITH THE FOLLOWING ACTIVITIES:

ACTIVITY	
1. READING	1. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A
2. SEEING TRAFFIC AND STREET SIGNS	2. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A
3. SEWING, CROCHETING, NEEDWORK, TYING A FISHING LINE	3. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A
4. WATCHING TV	4. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A
5. WORKING AT MY JOB	5. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A
6. MANAGING MY HOUSEHOLD	6. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A
7. PLAYING SPORTS (GOLF, TENNIS, SKIING, ETC.)	7. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A
8. ENJOYING RECREATIONAL OR LEISURE ACTIVITIES	8. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A
SYMPTOMS	
1. POOR NIGHT VISION	1. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A
2. SEEING RINGS OR HALOS AROUND LIGHTS	2. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A
3. GLARE	3. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A
4. HAZY OR BLURRED VISION	4. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A
5. SEEING IN POOR OR DIM LIGHT	5. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A
6. DIFFICULTY WITH DEPTH PERCEPTION	6. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A
7. DIFFICULTY WITH COLOR VISION	7. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A
DRIVING	
1. DO YOU DRIVE?	1. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A
2. ARE YOU CURRENTLY ABLE TO DRIVE DURING DAYLIGHT HOURS?	2. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A
3. ARE YOU CURRENTLY ABLE TO DRIVE DURING THE NIGHTTIME HOURS?	3. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A
4. DO PROBLEMS WITH YOUR SIGHT CAUSE YOU TO BE FEARFUL WHEN YOU DRIVE DURING THE DAY?	4. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A
5. DO PROBLEMS WITH YOUR SIGHT CAUSE YOU TO BE FEARFUL WHEN YOU DRIVE AT NIGHT?	5. ☐ Always ☐ Sometimes ☐ Never ☐ Do Not Know or N/A

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MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ DOB: _____/_____/_____ DATE: _____/_____/_____

Referring Provider: _____ Primary Care Provider: _____

Eye Doctor: _____ Specialist: _____

Emergency Contact _____ Relation: _____ Phone Number: _____

REVIEW OF SYSTEMS Do you presently have any problems in the following areas?

Integument (skin)	YES	NO	Bones, Joints, Muscles, Arthritis	YES	NO
Eyes	YES	NO	Neurological (stroke)	YES	NO
Ears, Nose, Mouth, Throat	YES	NO	Lymphatic (lymph nodes/swelling)	YES	NO
Breasts	YES	NO	Hematopoietic (blood)	YES	NO
Neck	YES	NO	Cancer	YES	NO
Respiratory (lungs)	YES	NO	Endocrine (diabetes/thyroid)	YES	NO
Cardiovascular (heart/high blood pressure)	YES	NO	Allergic & Immunologic	YES	NO
Gastrointestinal (stomach/intestines)	YES	NO	Psychiatric	YES	NO
Genitourinary (genitals/kidneys/bladder)	YES	NO	Are you currently pregnant or breastfeeding?	YES	NO

If yes to any of the above, please explain: _____

_____

_____

List any medications you take: _____

_____

_____

List any surgeries you have had in the past: _____

_____

Do you have allergies to any medications? □ YES □ NO If YES, list the medications: _____

Do you have other allergies? □ YES □ NO If YES, list the allergy: _____

FAMILY HISTORY			**RELATIONSHIP TO PATIENT**
Glaucoma	YES	NO	_____
Macular Degeneration	YES	NO	_____
SOCIAL HISTORY			
Do you use cannabis?	YES	NO	
Do you use recreational drugs?	YES	NO	If YES, please specify: _____
Do you drink alcohol?	YES	NO	If YES, how many glasses a day?: _____
Do you smoke?	YES	NO	If YES, how many packs a day? _____

MARITAL STATUS: □ Single □ Married □ Divorced □ Widowed □ Other _____

PRESENT OCCUPATION: _____

What kind of work have you done in the past? _____

EDUCATION LEVEL: □ High School Graduate □ College Graduate □ Post Graduate Degree □ Other: _____

PREFERRED PHARMACY: _____ City/Town: _____

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