Pendleton
EYE CENTER
A PROFESSIONAL CORPORATION

"A Difference You Can See..."

Lifestyle Vision Questionnaire

Name _____ **Date** _____

We would like to understand more about how you use your eyes now and how you would LIKE to see after surgery. Please answer the following:

1. Do you currently wear glasses? Yes _____ No _____

If yes, check all that apply:

____ **Distance** (driving, TV) ____ **Intermediate** (computer, music stand) ____ **Near** (reading, sewing)

2. How do you feel about wearing glasses? _____

_____

3. If it were possible to go most of the time **without glasses,** would you like that? Yes _____ No _____

4. What type of outcome would you like after cataract surgery? (check all that apply)

_____ Reduced need for glasses _____ See better than I did before surgery

5. Please **CHECK** activities you do on a regular basis. **CIRCLE** those activities you would LIKE to do WITHOUT glasses.

___Read (newspapers, books, etc.)
I read _____ hrs. per day
___Needlepoint, sew
___Crossword puzzles
___Water sports
___Drive daytime
___Drive nighttime
___Shop
___Play tennis
___Hunt or fish
___Paint or draw
___Watch spectator sports
___Dine in restaurants
___Bicycle
___Play cards, board games
___Use the computer: ____hrs. per day
__Golf
__Use cell phone
__Watch TV
__Watch movies in theater
__Photography
__Cook
__Visit /care for grandchildren

6. Please list any activities **you have given up** due to your eyesight? _____

_____

7. How important is it for you to read, watch TV, or use the computer without glasses?

_____Very important _____Important _____Not important

8. Please place an X on the following scale to describe your personality as best you can.

Easy going ..... Perfectionist

Patient signature: _____