

CATARACT & LASIK CENTER OF UTAH

DOCUMENTATION OF PATIENT SYMPTOMS REGARDING FUNCTIONAL VISUAL NEEDS

Patient Name: _____

For office use only:

____ Cataract Surgery

____ YAG Capsulotomy

PRE-OPERATIVE ASSESSMENT

To be filled out by patient or relative:

<i>With glasses on, do you have difficulty with.....</i>	<i>Please circle YES or NO</i>	
1) Reading small print?	YES	NO
2) Recognizing people or objects?	YES	NO
3) Judging distances, seeing steps, stairs or curbs?	YES	NO
4) Reading traffic signs, street signs or store signs?	YES	NO
5) Doing find handwork like sewing, knitting or carpentry?	YES	NO
6) Writing checks or filling out forms?	YES	NO
7) Playing games such as bingo, dominoes or cards?	YES	NO
8) Taking part in sports like hunting, golf or tennis?	YES	NO
9) Performing daily household activities, cooking, cleaning, etc.?	YES	NO
10) Watching television?	YES	NO
11) Do you drive a car?	YES	NO
If NO, did you stop because of your vision?	YES	NO
12) Does the glare from sunlight and headlights impair your driving ability?	YES	NO
Other:	YES	

Are the symptoms: (Please check one)

Worse in the right eye? _____

Worse in the left eye? _____

Equal in both eyes? _____

Patient Signature: _____

Witness Signature: _____

Date: _____