Vision Preferences Checklist

When cataract surgery is performed, an artificial lens (IOL) is inserted to replace the human lens that has become hard & clouded. With advances in today’s lens technology, combined with precision laser surgery enhancements, vision after cataract surgery can be improved like never before!

Cataract surgery is a once-in-a-lifetime procedure with an opportunity to permanently change how you see the world. Your Florida Eye Institute team will help educate you about the variety of choices available. This questionnaire can provide insight on how you expect to see after cataract surgery.

It is important to understand that most patients will need glasses for some activities after cataract surgery.

◊ Are you interested in seeing well in the distance without glasses? □ Yes □ No

◊ Are you interested in seeing well near (arms-length and within) without glasses? □ Yes □ No

◊ What near vision, hand/eye activities do you enjoy or perform often? (check all that apply)
  □ Carpentry □ Painting □ Cooking □ Piano / Reading Music □ Driving □ Cards □ Gardening
  □ Puzzles / Crosswords □ Needlepoint / Knitting / Crocheting □ Reading Books / Newspaper
  □ Reading Mobile Phone / Tablet

◊ What activities do you enjoy / perform most often? (check all that apply)
  □ Biking □ Fishing □ Bowling □ Hunting □ Computer □ Shopping □ Golfing □ Swimming
  □ Driving (Night / Day) □ Tennis □ Time with kids’ □ Traveling □ Watching TV □ Writing
  □ Others_________________________________________________

◊ How enjoyable would it be for you to be free of glasses for all of your daily activities?
  □ Awesome □ Very Nice □ OK □ Not a Big Deal

◊ Do you do a lot of night driving? □ Yes □ No □ Somewhat

◊ How would you describe your personality? (Place an “X” on the following scale)

Easy Going------------------------------------------|-----------------------------------------------Perfectionist

◊ Please tell us about any other lifestyle visual concerns you have: ____________________________

____________________________________________________

Patient Name: ____________________________ DOB: ____________ Date: ______________________