Dr Lior Lipsky - Specialist Eye Surgeon

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Questionnaire for Cataract Patients

Please bring this form with you to your clinic appointment

Date: __ / __ / _____

Name_____ Surname _____ Date of birth __ / __ / _____

1. Throughout the day, you perform activities that require your eyes to focus at different distances.
   Circle or write in the activities that are most important for your lifestyle:

DISTANCE

Driving

Golf

Sporting events

Scenery

OTHER

INTERMEDIATE

Car dashboard

Computer

Grocery shopping

Mobile phone or tablet

OTHER

NEAR

Fine print

Games & puzzles

Sewing

Makeup

OTHER

LOW LIGHT ACTIVITIES

Night time driving

Concerts

Musicals

Evening reading

OTHER

2. Thinking long-term, how important is it to you to be less dependent on glasses?
   - ☐ I do not mind wearing glasses
   - ☐ It would be nice not to wear glasses
   - ☐ Glasses are annoying
   - ☐ I hate wearing glasses

3. If you could have good vision at all distances (far, intermediate and near) without glasses, but the trade-off was that you would likely see some rings or starbursts around light at night, would you choose that option?
   - ☐ Yes, it would not bother me
   - ☐ Possibly
   - ☐ Not likely
   - ☐ Definitely not

4. How often do you drive in low lighting conditions (dusk, night, dawn, rain)
   - ☐ Frequently
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never

5. Place an "X" on the following scale to describe your personality as best as you can

   [_____I_____]
   Easy-going Perfectionist

6. Your occupation (former if retired) and/or hobbies
   _____
   _____
   _____

7. Please share any questions or concerns you would like us to know about
   _____
   _____
   _____