

## Cataract Visual Assessment Questionnaire

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

This information assists in determining the level of functional impairment of vision in patients with cataracts.

*Please check the appropriate box for each question.*

	<u>No</u>	<u>A little difficulty</u>	<u>Moderate difficulty</u>	<u>A great deal of difficulty</u>	<u>Unable to do this activity</u>
Do you have any difficulty, even with glasses, reading small print, such as labels on medicine bottles, a telephone book, or food labels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any difficulty, even with glasses, reading a newspaper or a book?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any difficulty, even with glasses, reading a large-print book or numbers on a telephone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any difficulty, even with glasses, seeing steps, stairs or curbs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any difficulty, even with glasses, reading traffic signs, street signs, or store signs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any difficulty, even with glasses, doing fine handwork like sewing, knitting, crocheting, or carpentry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any difficulty, even with glasses, writing checks or filling out forms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any difficulty, even with glasses, playing games such as bingo, dominos, card games, mahjong?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any difficulty, even with glasses, taking part in sports like bowling, handball, tennis, golf?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any difficulty, even with glasses, watching television?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much difficulty do you have driving during the day because of your vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much difficulty do you have driving at night because of your vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_