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:

With glasses on, do you have difficulty with…..	***Please circle YES or NO***
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 NO

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:_____