Name: _____

Date of Birth:

DAVIS VISION CENTER
THE CLEAR CHOICE FOR EYES

Cataract Symptom Questionnaire

Visual function

Do you have difficulty with the following activities, even with glasses?

- Reading small print such as labels on medication bottle or food?.....Yes No
- Reading a book or newspaper?.....Yes No
- Reading a large print book or newspaper or large numbers on the phone?.....Yes No
- Recognizing people when they are close to you?.....Yes No
- Seeing steps, stairs or curbs?.....Yes No
- Reading traffic signs, street signs or store signs?.....Yes No
- Doing fine handwork like sewing, knitting or carpentry?.....Yes No
- Writing checks or filling out forms?.....Yes No
- Taking part in sports like bowling, tennis or golf?.....Yes No
- Cooking?.....Yes No
- Watching television?.....Yes No

Symptoms

Have you been bothered by:

- Poor night vision?.....Yes No
- Seeing rings or halos around lights?.....Yes No

- Glaring caused by headlights or bright sunlight?.....Yes No
- Hazy and/or blurry vision?.....Yes No
- Seeing well in poor or dim light?.....Yes No
- Poor color vision?.....Yes No
- Double vision?.....Yes No

Driving

Circle the appropriate answer

- How much difficulty do you have **driving during the day** because of your vision?

no difficulty a little difficulty a moderate amount of difficulty a great deal of difficulty

- How much difficulty do you have **driving at night** because of your vision?

no difficulty a little difficulty a moderate amount of difficulty a great deal of difficulty

Patient signature: _____ date: _____