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BOARD CERTIFIED

Visual Assessment to Determine Medical Necessity for Cataract Surgery

In order to help determine if cataract surgery is advisable for you, please answer the following questions. Thank you!

Name: _____ DOB: ____/____/____ Date: _____

Do you have difficulty, even with glasses or contact lenses with any of the following activities? **YES** **NO**

- | | | |
|--|--------------------------|--------------------------|
| 1. Reading a newspaper, magazine or doing your paperwork?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Reading fine print such as a phone book, medicine bottle or food labels?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Driving during daylight?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Driving at night?.....Or in poor weather?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Seeing street signs, traffic signs or store signs?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Doing fine handwork such as sewing, threading a needle, hobbies or carpentry? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Recognizing people until they get close to you?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Seeing the television or computer clearly?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Writing checks or filling out forms?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Playing games such as cards, bingo, lottery games or others?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Taking part in sports like golf, tennis, hunting, bowling or others?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Cleaning, cooking or other housework of any kind?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Seeing curbs, steps or stairs?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Performing any duties required for your work?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Any other problems with your daily activities caused by poor vision?..... | <input type="checkbox"/> | <input type="checkbox"/> |

SYMPTOMS *Are you bothered by any of the following?*

- | | | |
|--|--------------------------|--------------------------|
| 1. Hazy and/or blurry vision? Difficulty focusing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Poor night vision or difficulty seeing in dim lighting?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Glare, halos or streaks around lights?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Glare from car headlights or bright sunlight?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. It often seems like I am looking through glasses that need cleaning?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Signature: _____ Date: _____