Patient Name _____ DOB _____/_____/_____

Patient Lifestyle Questionnaire

The Kansas City Eye Clinic recognizes that your eyes are very important and want to provide the best care to you and your vision. The information you provide in this questionnaire will help us determine the best recommendations for your eyes and your lifestyle after cataract surgery. Please fill out this form, bring it to your appointment, and give to the technician/nurse before seeing the doctor.

1. Are you interested in seeing well **at distance** without glasses after surgery?
   [ ] Yes, prefer no distance glasses [ ] Not important, don't mind wearing distance glasses

2. Are you interested in seeing well **at near** without glasses after surgery?
   [ ] Yes, prefer no reading glasses [ ] Not important, don't mind wearing reading glasses

3. Circle the activities that are most important to you:

Distance Vision	**Intermediate Vision**	**Near Vision**
Driving – daytime	Seeing car dashboard	Reading books/newspaper
Driving – nighttime	Using computer	Crossword puzzles
Golfing/Other sports	Using tablet	Using cell phone
Watching movies/theater	Shopping	Sewing/Needlework
Viewing scenery/Taking photographs	Playing cards	Applying makeup
	Cooking	Shaving
Hunting/Fishing	Gardening	Other_____
Other_____	Other_____	

4. How important is the opportunity to do most of the activities that you enjoy with a **minimal need for glasses** after cataract surgery?
   [ ] Very Important [ ] Important [ ] Somewhat Important [ ] Not Important

5. If you had to wear glasses after surgery for one activity, for which activity would you be **most** willing to use glasses?
   [ ] Reading fine print [ ] Computer [ ] Driving

6. Would you accept seeing **some faint rings/halos** around lights at night in order to be able to have **good distance vision without glasses and good near vision without glasses**?
   [ ] Yes [ ] No

7. Place an "X" on the line where you would rate your personality:

   Easy Going_____Perfectionist

8. What is your profession? _____

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