

Pre-Cataract Surgery Questionnaire - Visual Functioning Index

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

4 = no difficulty **3** = yes, little difficulty **2** = yes, moderate difficulty **1** = yes, great deal of difficulty
0 = yes, unable to do the activity **N/A** = not applicable

1. Reading small print such as labels on medicine bottles, a telephone book or food labels?	<input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> N/A
2. Reading a newspaper or book?	<input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> N/A
3. Reading a large-print book or large-print newspaper or numbers on a telephone?	<input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> N/A
4. Recognizing people when they are close to you?	<input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> N/A
5. Seeing steps, stairs or curbs?	<input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> N/A
6. Reading traffic signs, street signs or store signs?	<input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> N/A
7. Doing fine handwork like sewing, knitting, crocheting or carpentry?	<input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> N/A
8. Writing checks or filling out forms?	<input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> N/A
9. Playing games such as bingo, dominos, card games or mahjong?	<input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> N/A
10. Taking part in sports like bowling, handball, tennis or golf?	<input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> N/A
11. Cooking?	<input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> N/A
12. Watching television?	<input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> N/A
13. Do you currently drive a car?	<input type="checkbox"/> Yes, go to #14 <input type="checkbox"/> No, go to #16
14. Do you have difficulty driving during the day?	<input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0
15. Do you have difficulty driving at night?	<input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0
16. Have you ever driven a car?	<input type="checkbox"/> Yes, go to #17 <input type="checkbox"/> No, STOP
17. When did you stop driving?	<input type="checkbox"/> < 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> > 6 months
18. Why did you stop driving?	<input type="checkbox"/> Vision <input type="checkbox"/> Other illness <input type="checkbox"/> Other reason