Patient Name _____ DOB ____/____/____ Date ____/____/____

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