VISION CORRECTION AFTER SURGERY

NAME: ___________________ DATE OF BIRTH: ___________MRN: ________

Please indicate how knowledgeable you are about your cataract surgery options:

[] Not Knowledgeable [] Somewhat Knowledgeable []Comfortably Knowledgeable

Are you interested in not having to wear glasses after surgery?

[] YES [] No [] No preference [] Would like more information

Are you interested in <u>seeing well at a distance (driving, golf, etc.) without glasses</u> after surgery?

[] YES [] No [] No preference [] Would like more information

Are you interested in <u>seeing well at mid-range (computer, cooking, shopping, etc.) without glasses</u> after surgery?

[] YES [] No [] No preference [] Would like more information

Are you interested in <u>seeing well at near range (reading, sewing, etc.) without glasses</u> after surgery?

[] YES [] No [] No preference [] Would like more information

If you HAD to wear glasses after surgery for one activity, which would you be MOST WILLING to use glasses?

[] READING FINE PRINT [] COMPUTER [] DRIVING

If you could have good distance vision during the day without glasses, and good near vision for reading without glasses, but the compromise was that you might see glare and haloes around lights at night, would you like that option?

[] YES [] No [] No preference [] Would like more information

If you could have good distance vision during the day without glasses, and good mid-range vision for reading without glasses, but the compromise was that you would need glasses for extended reading or fine print, would you like that option?

[] YES [] No [] No preference [] Would like more information

Patient Signature: _________________________________ Date: ____________________