Cataract Evaluation Patient Questionnaire

*****Please bring completed to your next appointment with Dr. Landes*****

What are your hobbies and activities?

How much time do you spend reading or on the computer?

Are you able to read, see the computer, or see other things up close without glasses?

Do you want to read, see the computer, or see other things up close without glasses?

Do you drive at night? If so, does your vision make it difficult?

Have you ever worn contacts? If so, when did you last wear them?

Have you ever done monovision (one eye sees far, the other eye sees near)?

If you've done monovision, how well did it work for you/did you like it, and would you do it again?

Have you had refractive surgery (RK, LASIK, PRK)? If so, which eye(s), when, and where did you have it done?

Do you have a preference for laser assisted cataract surgery?

What are you goals for this surgery? How would you like to see after surgery?

Patient Name: ______________________________ Date: ______________