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Visual Needs Questionnaire

Your answers to the following questions will help us determine the solution that best meets your visual needs.

1. How many hours per week do you spend driving after dark? _____
2. How many hours per week do you spend working on a computer? _____
3. How many hours per week do you spend reading small print materials for extended periods (e.g. magazine, newspaper, paperback book)? _____
4. Do you wear contact lenses? Yes No
5. What type of glasses do you presently wear?
 Bifocal Progressive (lineless) Bifocal Trifocal Reading Only
 Distance only None
6. Do you currently wear glasses full time for both distance and reading? Yes No
7. If not, what percentage of time do you wear your glasses? _____
8. If you sometimes read without your glasses, what percentage of your reading is done with glasses? _____ without glasses? _____
9. If you had to choose just one of the following, which type of focus do you feel that you would prefer to have without glasses?
 Reading fine print Social reading (e.g. restaurant menu) Computer
 TV Driving
10. How important would reducing the need for glasses be for you after cataract/lens surgery?
 Extremely Very Somewhat Minimally
11. How many hours per week do you spend at outdoor activities (e.g. golf or other athletics, aviation)? _____

Please list any other activities, hobbies or sports that you consider an important part of your life. _____

Patient Signature

Date