

Patient Vision Questionnaire Sheet

Name: _____

Age: _____

Today's Date _____

1. My main visual problem: (check all that apply)

- Fine Print
- Near Vision
- Intermediate/Computer Vision
- Distance Vision
- Night Driving

2. My current prescription is for: (check all that apply)

- Myopia or nearsightedness
- Hyperopia or farsightedness
- Astigmatism
- Presbyopia (I wear bifocals or glasses for reading)
- I'm not sure

3. Do you currently wear: (check all that apply)

- Glasses for Distance
- Reading Glasses
- Bifocal or Progressive Glasses
- Daily Wear Contact Lenses
- Extended Wear Contact Lenses
- Toric Contact Lenses
- Monovision Contact Lenses
- Gas Perm or Hard Contact Lenses
- I do not wear any glasses or contact lenses
- Other

4. How much of the time would you estimate you wear a correction when: (please circle answer)

Driving?	0%	25%	50%	75%	100%
Reading?	0%	25%	50%	75%	100%
Using a Computer?	0%	25%	50%	75%	100%
Performing daily activities around the house?	0%	25%	50%	75%	100%

5. Do you use a computer? A Lot Moderate For Fun Not at All

6. What sports do you participate in? _____

7. What are your hobbies? _____

8. When are you planning on having surgery? I'm already scheduled As soon as possible
 Within 1-3 months Within 6 months Next year (FSA) Not sure

9. What are your expectations of this surgical procedure? _____
