



Name _____
 Occupation _____
 Date _____

Quality of Vision Checklist

When you have a lens implant or refractive procedure, it is important to consider your individual vision and lifestyle preferences to determine how best to provide you with optimum vision afterwards. Although it has not been determined if you are a candidate for any procedure, this Questionnaire will help us make recommendations during your eye exam.

Are you interested in seeing well at distance without glasses after surgery?

___ Yes ___ No I don't mind wearing glasses to see at distance.

Are you interested in seeing well at near without glasses after surgery?

___ Yes ___ No I don't mind wearing reading glasses.

Do glasses or contacts interfere with your job, hobbies, and recreational activities?

___ Yes ___ No If yes, which activities? _____

Which "Zone of Vision" is most important to you? Please choose only one group.

___ Zones 1, 2, 3 ___ Zones 2, 3, 4 ___ Zones 4, 5

Zone 1 (12-20 in)	Zone 2 (15-24 in)	Zone 3 (6-20 ft)	Zone 4 (20-100 ft)	Zone 5 (100+ ft)
Newsprint	Most Books	Indoors	Day-Far	Night-Far
Phone Book	Computer	TV	Day Driving	Movies
Maps	Menus	Cooking	Golf	Star Gazing
Sewing	Price Labels	Cleaning	Tennis	Night Driving

If you need glasses after surgery (always possible), for which one activity would you be the most willing to wear glasses?

___ Reading Fine Print ___ Computer ___ Driving

If you could have good daytime distance vision and good reading vision without glasses, but the compromise is that you might see circles or halos around lights at night, would you consider that an acceptable option?

___ Yes ___ No

Please mark anywhere on the following scale to describe your personality as best as you can.

Easy Going-----**Perfectionist**

Patient Signature: _____

-----*For Office Use Only*-----

Doctor Recommendation: ___ Monofocal ___ ReSTOR ___ ReZOOM ___ Crystalens