

**National Ophthalmic
Clinical Database Library**
Patient Questionnaire - Data Collection Form

FOR OFFICE USE ONLY

Patient Name: _____

Date of Procedure: ____ - ____ - ____

Operative Eye: OD OS
 Pre-Procedure Post-Procedure

VISUAL FUNCTIONING

**Does your sight make it a
problem for you to:**

	Always	Sometimes	Never	Don't Know
Read newspapers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Read a telephone book	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
See traffic signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Read labels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Read price tags	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recognize people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
See steps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
See cracks in the sidewalk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
See out of your other eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watch TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work at your job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage your home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enjoy recreation and leisure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SYMPTOMS

Have you been bothered by:

	Always	Sometimes	Never	Don't Know
Poor night vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing rings around lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hazy vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing in poor or dim light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DRIVING AND ACCIDENTS

Do you drive? Yes No

Are you currently able to drive:	Always	Sometimes	Never	Don't Know
During daylight hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During evening / night hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do problems with your sight cause you to be fearful when you drive:	Always	Sometimes	Never	Don't Know
During daylight hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During evening / night hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past six months, have you made any driving errors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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CURRENT VISION

How is your vision with your glasses or contacts now?
 Excellent Good Fair Poor Very Poor

SATISFACTION WITH CARE

How satisfied are you with your medical treatment?
 Excellent Good Fair Poor Very Poor

LIFE SATISFACTION

How do you feel about your life right now, on a scale of one to ten?
(Ten being the best and one being the worst)

Circle one: 1 2 3 4 5 6 7 8 9 10

ACTIVITIES AND DAILY LIFE

Are you usually able to:	Always	Sometimes	Never	Don't Know
Get around in your own home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get around in your own neighborhood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shop for groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature _____