

PAVELOFF

VISION CENTER

Visual Functioning for Cataract Extraction Consideration

1. Do you have any difficulty, even with glasses, reading small print such as labels on medicine bottles, a telephone book or food labels?

Yes No Not Applicable

If yes, how much difficulty do you currently have?

1. A little
2. A moderate amount
3. A great deal
4. Are you unable to do the activity?

2. Do you have any difficulty, even with glasses, reading a newspaper or book?

Yes No Not Applicable

If yes, how much difficulty do you currently have?

1. A little
2. A moderate amount
3. A great deal
4. Are you unable to do the activity?

3. Do you have any difficulty, even with glasses, seeing steps, stairs or curbs? Do you feel your depth perception is compromised?

Yes No Not Applicable

If yes, how much difficulty do you currently have?

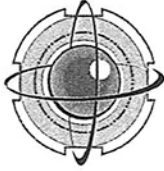
1. A little
2. A moderate amount
3. A great deal
4. Are you unable to do the activity?

4. Do you have any difficulty, even with glasses, reading traffic signs, street signs or with your distance vision?

Yes No Not Applicable

If yes, how much difficulty do you currently have?

1. A little
2. A moderate amount
3. A great deal
4. Are you unable to do the activity?



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5. Do you have difficulty with night vision or vision in dim light? Do halos and/or glare affect or compromise your vision at night?

Yes No Not Applicable

If yes, how much difficulty do you currently have?

1. A little
2. A moderate amount
3. A great deal
4. Are you unable to do the activity?

6. Do you have any difficulty, even with glasses, writing checks or filling out forms?

Yes No Not Applicable

If yes, how much difficulty do you currently have?

1. A little
2. A moderate amount
3. A great deal
4. Are you unable to do the activity?

7. Do you currently smoke or are you a former smoker?

Yes No Former

If yes,

1. Daily
2. Occasional

8. Do you have any difficulty, even with glasses, watching television?

Yes No Not Applicable

If yes, how much difficulty do you currently have?

1. A little
2. A moderate amount
3. A great deal
4. Are you unable to do the activity?

Please list any other visual symptoms you are experiencing:

Patient's Signature

Date