Stolte Eye Center

# Patient Lifestyle Questionnaire

Patient Name _____

Chart Number _____

Eye Being evaluated ☐ RT ☐ LT

## Visual Functioning

| Do you have difficulty, even with glasses, with the following activities? | YES | NO |
|---|---|---|
| 1. Reading small print, such as labels on medicine bottles, telephone books, food labels? | ☐ | ☐ |
| 2. Reading a newspaper or book? | ☐ | ☐ |
| 3. Reading a large-print book, or large-print newspaper, or large numbers on a telephone? | ☐ | ☐ |
| 4. Recognizing people when they are close to you? | ☐ | ☐ |
| 5. Seeing steps, stairs or curbs | ☐ | ☐ |
| 6. Reading traffic signs, street signs, or store signs? | ☐ | ☐ |
| 7. Doing fine handwork like sewing, knitting, crocheting, or carpentry? | ☐ | ☐ |
| 8. Writing checks or filling out forms? | ☐ | ☐ |
| 9. Playing games such as bingo, dominos or card games? | ☐ | ☐ |
| 10. Taking part in sports like bowling, handball, tennis, or golf? | ☐ | ☐ |

## Eyelid Functioning

| Lid Bleph Evaluation Form? | YES | NO |
|---|---|---|
| 1. Do your lids feel heavy or tired? | ☐ | ☐ |
| 2. Are you experiencing headaches towards the end of the day? | ☐ | ☐ |
| 3. Do you find you see better holding your eyelids up? | ☐ | ☐ |
| 4. Do you notice wrinkles in your forehead? | ☐ | ☐ |
| 5. Do you feel your lids are interfering with your side vision? | ☐ | ☐ |

## Symptoms

| Have you been bothered by: | YES | NO |
|---|---|---|
| 1. Poor night vision? | ☐ | ☐ |
| 2. Seeing rings or halos around lights? | ☐ | ☐ |
| 3. Glare caused by headlights or bright sunlight? | ☐ | ☐ |
| 4. Hazy and/ or blurry vision? | ☐ | ☐ |

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## Symptoms *(continued)*

| Have you been bothered by: | YES | NO |
|---|---|---|
| 5. Seeing well in poor or dim light? | ☐ | ☐ |
| 6. Poor color vision? | ☐ | ☐ |
| 7. Double vision? | ☐ | ☐ |

## Driving

| | YES | NO |
|---|---|---|
| 1. Have you ever driven a car? | ☐ | ☐ |
| 2. Do you currently drive a car? | ☐ | ☐ |

3. How much difficulty do you have driving during the day because of your vision?

☐ No difficulty ☐ A moderate amount of difficulty

☐ A little difficulty ☐ A great deal of difficulty

4. How much difficulty do you have driving at night because of your vision?

☐ No difficulty ☐ A moderate amount of difficulty

☐ A little difficulty ☐ A great deal of difficulty

5. When did you stop driving?

☐ Less than 6 months ago ☐ 6-12 months ago ☐ More than 1 year ago

Cataract Surgery can almost always be postponed until you feel you need better vision. If stronger glasses won't improve your vison anymore, and if the only way to help you see better Is cataract surgery, do you feel your vision problem is bad enough to consider cataract surgery?

☐ **YES** ☐ **NO**

Patient Signature _____ Date _____

Witness _____ Date _____