Name _____ Date _____/_____/_____

Lifestyle & Vision Questionnaire: Choosing the Right Lens for Your Lifestyle

This questionnaire is designed to help you and your doctor understand your daily activities, vision needs, and preferences. By answering these questions, you'll provide important insights that will guide the selection of the best lens option for your cataract surgery, tailored to your unique lifestyle.

1. Daily Activities

- **What are the top 3 activities you do most during the day?** (Examples: Reading, driving, working on a computer, cooking, exercising, applying makeup, using social media, sports, TV watching)
  1. _____
  2. _____
  3. _____

2. Prioritizing Vision Needs

- **Which is more important to you?**

☐ Clear distance vision (e.g., driving, watching TV)
☐ Clear near vision (e.g., reading, using a phone or tablet, social media, applying makeup)

3. Ranking Your Priorities

- **Rank the following in order of importance to you (1 = most important, 3 = least important):**

___ Clear distance vision (e.g., driving, watching TV)

___ Clear near vision (e.g., reading, using a phone, checking social media)

___ Reducing the need for glasses

4. Flexibility with Glasses

- **Are you willing to wear glasses for certain tasks if it means better vision for the activities you do most?**

☐ Yes, I don't mind wearing glasses occasionally.
☐ No, I prefer to avoid glasses as much as possible.

Name _____ Date _____/_____/_____

5. Near Vision Activities

- **How often do you engage in activities that require clear near vision?** (Examples: Reading, using a phone, checking social media, applying makeup, cooking)

☐ Daily
☐ A few times a week
☐ Rarely

6. Distance Vision Activities

- **How often do you engage in activities that require clear distance vision?** (Examples: Driving, watching TV, sports)

☐ Daily
☐ A few times a week
☐ Rarely

7. Nighttime Vision

- **If you could reduce your need for glasses but experience glare or halos at night, would you prefer this option?**

☐ Yes, I don't mind some glare or halos.
☐ No, I prefer clearer night vision, even if I need glasses.

8. Adjustment Period

- **How willing are you to go through an adjustment period for clearer long-term vision, knowing you may experience halos or glare initially?**

☐ I'm fine with an adjustment period, as long as it improves over time.
☐ I prefer as little adjustment time as possible, even if it limits some visual clarity.

9. Depth Perception

- **Do you participate in activities that require precise depth perception?** (Examples: Playing sports, driving, working with tools, hiking)

☐ Yes
☐ No

10. Astigmatism

- **Do you have astigmatism that you are aware of?**

☐ Yes
☐ No
☐ I'm not sure

11. Willingness to Compromise

- **Would you prefer the most flexible vision possible (seeing near, intermediate, and far) even if it involves some visual compromises (e.g., glare or halos)?**

☐ Yes, I'd prefer more flexibility.
☐ No, I'd prefer clearer vision at a set distance, even if I need glasses.

Name _____ Date _____/_____/_____

12. Physical Activity Level

- **How physically active are you, and how important is clear vision for your activities?** (Examples: Walking, hiking, sports)

☐ Very active—I'm involved in daily physical activities and need good vision for them.
☐ Moderately active—I'm involved in physical activities a few times a week.
☐ Not very active—Most of my activities don't require high physical effort.

13. Reading

- **How important is it to have clear vision for reading and close tasks without glasses?** (Examples: Reading books, using a phone, checking social media, using a tablet)

☐ Very important—I don't want to wear glasses for reading.
☐ Somewhat important—I don't mind using glasses for some close-up tasks.
☐ Not important—I'm comfortable wearing glasses for reading.

14. Hobbies and Interests

- **Do you have any specific hobbies or interests that require special vision considerations?** (Examples: Painting, woodworking, knitting)

☐ Yes
☐ No
If yes, please explain:

_____

15. Managing Glare

- **How concerned are you about experiencing glare or halos (particularly at night)?**

☐ Very concerned—I do a lot of driving or activities at night.
☐ Somewhat concerned—I occasionally drive at night but it's not a major factor.
☐ Not concerned—Nighttime activities are not frequent for me.

16. Future Expectations

- **How important is it for you to reduce your dependence on glasses long-term?**

☐ Very important—I don't want to rely on glasses in the future.
☐ Somewhat important—I prefer to reduce my use of glasses but don't mind them for certain tasks.
☐ Not important—I'm comfortable using glasses regularly.

17. Please place an "X" on the following scale to describe your ability to adapt to changes?

[_____|_____]

Flexible Slow to Adjust

18. Please place an "X" on the following scale to describe your personality?

[_____|_____]

Easy-going Perfectionist/Detailed oriented

Name _____ Date _____/_____/_____

19. Special Considerations

- **Is there anything specific about your lifestyle or vision that you would like to share with your doctor?** (e.g., specific visual demands from your work, hobbies, or daily life)
  - _____
  - _____
  - _____
  - _____

20. Are you willing to pay out of pocket for premium technology options to enhance your cataract surgery results?

☐ Yes

☐ No