Dear Patient: To better serve your visual needs, please take the appropriate time to fill out this questionnaire to help us meet your expectations. This information you provide will help us determine the best recommendation for your vision & overall health:

What near or close activities do you regularly enjoy?

Reading ____ Cooking ____ Sewing ____ Computer ____ Other (please list)______________

What additional recreational activities do you currently enjoy?

Walking ____ Golf ____ Gardening ____ Swimming ____ Other (please list)_______________

How important is the opportunity to do **most** of the activities you enjoy with a minimal need for glasses after cataract surgery?

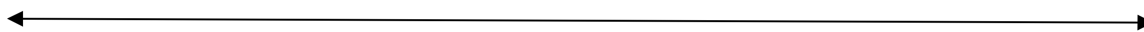
Very Important ____ Important ____ Somewhat Important ____ Not important ____

Would you accept seeing some faint rings around lights at night to able to see better up close without glasses? Yes____ No____

If your doctor determines that you are an appropriate candidate for advanced technology currently available, would you like to hear about a lens option that could significantly reduce/possibly eliminate the need for glasses?

Yes, I would like to hear about that option____________ No, I am not interested __________

Place an "X" on the line where you would rate your personality:



Easy Going Perfectionist

Please share any vision concerns that you have been experiencing or questions you have:

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Thank you for completing this questionnaire and please hand this to the technician assisting you during your visit. We greatly appreciate your decision to have us serve your visual needs. We sincerely hope that your visit will be enjoyable and that you will recommend our office to your friends & family!