J. Gregory Jones M.D.

Cataract Evaluation Questionnaire

Patient's Name_____

What is your current occupation? _____

Please check YES or NO to the following questions:

Do you have difficulty reading small print such as a pill bottle label, newspaper, or the telephone book? YES__ NO__

Do you have difficulty reading traffic signs, street signs, or store signs? YES__ NO__

Do you have difficulty writing checks or filling out forms? YES__ NO__

Do you experience poor night vision? YES__ NO__

Do you experience glare caused by headlights or bright sunlight? YES__ NO__

Do you experience double vision? YES__ NO__

Do you use a computer frequently? YES__ NO__

Do you do a lot of close detailed work? YES__ NO__

Have you ever tried monovision contact lenses? YES__ NO__

If YES to the previous question, did you like it? YES__ NO__

Have you ever had LASIK or any other refractive surgery before? YES__ NO__

Do you CURRENTLY (or have PREVIOUSLY in the past) take any of the following medications?

Flomax: YES__ NO__

Hytrin: YES__ NO__

Cardura YES__ NO__

Uroxatral: YES__ NO__

Rapaflo YES__ NO__