

INSTRUCTIONS:

This survey asks for information about your **vision**. Please answer the questions based upon your **best vision with your glasses or contact lenses**. This information will be summarized in your medical record and will help your doctors keep track of how well you are able to do your usual activities.

Answer every question by marking the appropriate box for each question. If you are unsure about how to answer a question, please give the best answer you can.

1. How would you rate your vision (how well do you see using both eyes)?

- Excellent 100.476
- Very Good
- Good
- Fair
- Poor

2. How does bright light affect your vision (when using both eyes)?

- It makes it much better 100.477
- It makes it a little better
- No change
- It makes it a little worse
- It makes it much worse

3. How would you rate the vision in your right eye?

- Excellent 100.478
- Very good
- Good
- Fair
- Poor

4. How would you rate the vision in your left eye?

- Excellent
- Very good
- Good
- Fair
- Poor

5. How much does your vision hinder, limit or disable you in each of the following activities? (Please mark one box on each line.)

	not at all limited	slightly limited	some- what limited	moder- ately limited	extremely limited	don't do for other reasons
a. Your usual daily activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Recognizing people or objects across the street	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Daytime driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Nighttime driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Reading street or freeway signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Seeing traffic lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. How much does your vision hinder, limit, or disable you in the following close-up activities?

	not at all limited	slightly limited	some- what limited	moder- ately limited	extremely limited	don't do for other reasons
a. Reading a magazine, newspaper, or telephone book	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Crafts or hobbies (sewing, painting, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Reading labels or prices in stores or supermarkets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Depth perception (pouring coffee, hitting a golf ball, parking a car)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

100.481

7. How much are you hindered, limited or disabled by glare (dazzling light) in each of the following activities?

	not at all limited	slightly limited	some- what limited	moder- ately limited	extremely limited	don't do for other reasons
a. Your usual daily activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Reading shiny paper (such as magazine pages)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Driving towards the sun or oncoming headlights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Walking outside on a sunny day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Reading signs in supermarkets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

100.493

8. After surgery, I expect my vision to be:

- Excellent 100.494
- Very Good
- Good
- Fair
- Poor

9. How much do you expect the performance of your usual daily activities to improve after surgery?

- Not at all 100.495
- A little bit
- Some
- Quite a lot