

**INTRAOCCULAR LENS SURGERY QUESTIONNAIRE**

Please check the activities based on vision type that are most important for your lifestyle:

**DISTANCE VISION**

- Driving     Sports     Television     Outdoor activities  
 Other \_\_\_\_\_

**INTERMEDIATE VISION**

- Computer     Mobile phone     Music/art     Baking/cooking  
 Other \_\_\_\_\_

**NEAR VISION**

- Reading     Games/puzzles     Sewing/crocheting     Model making  
 Other \_\_\_\_\_

On average, how many hours per day do you spend on the following activities:

- \_\_\_ Driving    \_\_\_ Phone/tablet    \_\_\_ Reading    \_\_\_ Hobbies

How often do you drive at night:

- Often     Occasionally     Rarely     Never

Which of the following best describes your personality:

- Easygoing     Flexible     Organized     Perfectionist

Following surgery, how important is it for you to be less dependent on eyeglasses:

- Extremely     Moderately     Somewhat     Not important

How knowledgeable are you about intraocular lens options:

- Extremely     Moderately     Somewhat     Not knowledgeable

Please write any questions or concerns you may have about intraocular lens surgery:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_