

VISION FOR YOUR LIFESTYLE.

SURVEY FOR CATARACT PATIENTS

You have an important decision to make about your vision future.

This survey is designed to help us understand your vision goals so we can provide you with the best possible lens for your lifestyle.

1 Throughout the day, you perform activities that require your eyes to focus at different distances.

Circle or write in the activities that are most important for your lifestyle:

DISTANCE



OTHER

INTERMEDIATE



OTHER

NEAR



OTHER

2

On average, how many hours per day do you spend:

please indicate the number next to the activity;

___ Driving	___ Engaging in lifestyle activities (i.e. golf, gardening, cooking, etc.)	___ Using media devices (i.e. mobile phone, tablet, e-reader)	___ Reading books, newspapers	___ Knitting, reading fine print
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3

Thinking long-term, how important is it that you rely on your glasses less often?

<input type="checkbox"/> I don't mind	<input type="checkbox"/> It'd be nice	<input type="checkbox"/> Glasses are annoying	<input type="checkbox"/> I hate wearing them
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4

How often do you drive in low-light conditions (dusk, night, dawn, rain)?

<input type="checkbox"/> Never	<input type="checkbox"/> Not often, but I'd like to	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often
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5

As best you can, mark where your personality type fits on this scale.

■ _____ ■

Easygoing Perfectionist

6

I know that my insurance may only cover some of the procedure, and I want to learn about my treatment options.

<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree
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If my procedure is not fully covered by insurance, I want to learn about financing options.

<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree
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7

To ensure your visit is a great experience, please share any questions or concerns you would like us to know about.
