

# 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

 Driving

 Golf

 Sporting events

 Scenery

OTHER

### INTERMEDIATE

 Car dashboard

 Computer

 Grocery shopping

 Mobile phone or tablet

OTHER

### NEAR

 Fine print

 Games & puzzles

 Sewing

 Makeup

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?**

I don't mind     
  It'd be nice     
  Glasses are annoying     
  I hate wearing them

4

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

Never     
  Not often, but I'd like to     
  Occasionally     
  Often

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.**

**If my procedure is not fully covered by insurance, I want to learn about financing options.**

Agree     
  Disagree     
  Agree     
  Disagree

7

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

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