Patient Activities Questionnaire

Patient Name_____ Date_____

1. Does wearing glasses bother or frustrate you?…….. ……..	Yes	No	Somewhat
2. Would it bother you if you had to wear glasses for some tasks?……	Yes	No	Somewhat
3. Do you do a lot of night driving?……	Yes	No	Somewhat
4. Do you notice halos or rings around lights when driving at night?……..	Yes	No	Somewhat
5. Would it bother you if you noticed some halos around lights at night?…….	Yes	No	Somewhat
6.Do you use a computer on a daily basis?……	Yes	No	Somewhat
7. Do you do a lot of close detail work?……	Yes	No	Somewhat
8. Have you ever tried monovision contact lenses?……..	Yes	No	Somewhat

In order of importance to you, list 3 activities you would like to do without glasses: (read, drive, etc..)

1._____

2._____

3._____

10. Select up to 3 groups you would prefer to see without glasses:

NYSE	Newsprint	TV	Day-far	Night-far
Phonebook	Menu	Meals	Driving	Night-driving
Drug labels	Makeup	Cooking	Golf	Movies
Maps	Price tags	Clocks	Road signs	Theater
Sewing	Cell phone	Cleaning	Sightseeing	Sporting Events
Cross stitching	Computer	Gardening	Bowling	Candlelight

11. Place an "**X**" on the scale to describe your personality:

_____

Easy going Perfectionist