Cataract questionnaire

START Name ….. Date …../…../20.....

<u>Please answer all 5 questions by marking the MOST appropriate BOX</u>

All questions relate to your vision within the PAST MONTH

	Yes A very great deal	**Yes** A great deal	**Yes** Sometimes	**No** Never
1. Has your overall vision been affected by your "worst" seeing eye?	☐	☐	☐	☐
2. Has your eyesight interfered with life in general?	☐	☐	☐	☐
3. Has your vision prevented you performing your usual daily activities?	☐	☐	☐	☐
4. Does your vision affect your reading of **normal** print in books or newspapers?	☐	☐	☐	☐
	Very satisfied	**Fairly satisfied**	**Rather dissatisfied**	**Very dissatisfied**
5. How satisfied or dissatisfied are You with your vision overall?	☐	☐	☐	☐