Name:
DOB:
Chart:
Age:
Date:

SHAREDID-46

EYE CONSULTANTS OF NORTHERN VIRGINIA, PC

Patient Name Name Date AppDate

Occupation _____

Vision Preference Questionnaire

When you have an intraocular lens implant or a refractive procedure, it is important to consider your individual vision and lifestyle preferences to determine how best to provide you with optimum vision afterwards. Although it has not yet been determined if you are a candidate for any procedure, this Questionnaire may clarify the best options for you and help us make recommendations during your eye examination.

Please consider the following questions:

INTRAOCULAR LENS
OR PROCEDURE THAT
MAY BE RIGHT FOR YOU

Do you plan to wear bifocals after surgery? Yes___ No___ If "Yes"

Monofocal IOL-standard

If "Yes" stop here. If "No"

Would you like glasses-free distance vision
but don't mind wearing reading glasses? Yes___ No___ If "Yes"

Femtosecond Laser
Toric IOL
Monofocal IOL

If "Yes" stop here. If "No"

Would you like to be less dependent on
glasses for distance and near functions? Yes___ No___ If "Yes"

Blended Vision
Multifocal IOL
Pseudo-accommodating IOL

Based on your ophthalmic history and examination as well as your lifestyle preferences, your Surgeon will recommend the options that are best for you.

_____
Your Signature

Doctor Recommendation: ____Monofocal IOL ____Toric IOL ____Blended Vision

_____Pseudo-accommodating IOL ____Multifocal IOL ____Femtosecond Laser

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PLEASE CIRCLE YOUR RESPONSE ON EACH LINE
(Please leave blank if it does not apply)

Have you been bothered by:	Answer		Comments
Overall decline in vision	YES	NO	
Blurry Vision	YES	NO	
Glare or poor night vision	YES	NO	
Sensitivity to light	YES	NO	
Seeing rings or halos around lights	YES	NO	
Seeing double	YES	NO	

Have you noticed a decrease in your vision when you:	Answer		Comments
Drive during daylight hours	YES	NO	
Drive during nighttime hours	YES	NO	
See traffic or road signs	YES	NO	
Read newspapers or telephone books	YES	NO	
Read labels, price tags or medicine bottles	YES	NO	
Use a computer	YES	NO	
Do fine handwork or hobbies	YES	NO	
Look at colors	YES	NO	
Do crossword puzzles	YES	NO	
Play cards	YES	NO	
Watch TV	YES	NO	
Look out of only one eye	YES	NO	
Other			

Patient's Signature: _____ **Date:** _____