Capital Eye Consultants

Activities of Daily Living Assessment

You cannot be seen until this form is filled out in its entirety

Patient Name: (Print) _____ *DOB:* _____

This questionnaire is required by Medicare and other insurers to document your reasons for considering cataract surgery. *If you have little or no difficulty you may not need or qualify for cataract surgery at this time.* It is also required that you sign and date this form.

Please accurately rate your concerns with your best vision (wear your glasses or contacts if you currently wear them). If one eye has less clear vision than the other, focus your rating on the eye that is less clear.

PLEASE CIRCLE YOUR RESPONSE ON EACH LINE

Generally, have you been bothered by:	*Answer*				*Comments*
Overall decline in vision	*No*	*Little*	*Some*	*A lot*	
Blurry Vision	*No*	*Little*	*Some*	*A lot*	
Poor night vision	*No*	*Little*	*Some*	*A lot*	
Glare, halo or sensitivity to light	*No*	*Little*	*Some*	*A lot*	

Specifically, have you noticed vision issues:	*Answer*				*Comments*
Seeing to drive during daytime	*No*	*Little*	*Some*	*A lot*	
Seeing to drive during nighttime	*No*	*Little*	*Some*	*A lot*	
Seeing traffic and street signs	*No*	*Little*	*Some*	*A lot*	
Reading labels and tags	*No*	*Little*	*Some*	*A lot*	
Reading text on a computer	*No*	*Little*	*Some*	*A lot*	
Reading a book or newspaper	*No*	*Little*	*Some*	*A lot*	
Reading text on TV	*No*	*Little*	*Some*	*A lot*	
Seeing to fill out a form, receipt, or check	*No*	*Little*	*Some*	*A lot*	
Seeing to walk on uneven surfaces, curbs, and steps	*No*	*Little*	*Some*	*A lot*	
Seeing to prepare a meal	*No*	*Little*	*Some*	*A lot*	
Seeing to enjoy your hobbies	*No*	*Little*	*Some*	*A lot*	

I realize that cataract surgery is an elective and optional surgery and the symptoms noted above are bothersome enough for me to seek cataract surgery to improve my vision. _____ (**Initial**)

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