This check list does not need to be filled out unless you are a patient with cataracts.

GTOC
GRAND TRAVERSE OPHTHALMOLOGY CLINIC

Name _____ Date _____

QUALITY OF VISION CHECKLIST

This short check list can assist us in determining which intra-ocular lens (IOL) best matches your visual needs. Advanced technology IOLs can provide good vision without glasses in many individuals.

- What activities are most important for you to perform without glasses?

_____ Driving	_____ Watching movies	_____ Shaving
_____ Reading	_____ Sewing	_____ Crossword puzzles
_____ Cooking	_____ Computer	_____ Watching TV
_____ Golfing	_____ Applying make-up	_____ Other _____

- Do you do a lot of night driving? Yes _____ No _____
- Do you do a lot of computer work? Yes _____ No _____
- Is it your goal to see without glasses for Distance, _____ Near, _____
  _____ both or _____ don't mind wearing glasses as long as I see well.

- How would you rate your personality? (please mark on line)

Easy Going **Perfectionist**

- What is or was (if retired) your occupation? _____

Do you have any specific visual needs or concerns?

_____

_____

_____

Patient Signature: _____