POST OPERATIVE QUESTIONNAIRE

Patient details
Name: D.O.B:

Address:

Before your cataract operation we asked you to complete a questionnaire to establish what difficulties you have in your daily life due to impaired sight. So that we can develop our healthcare as well as possible we are keen for you to answer the questions in this questionnaire as honestly as you can.

The questionnaire contains questions about your difficulties due to impaired sight in connection with certain everyday tasks. If you use glasses for distance and/or close-up purposes, the questions are about what it is like when you use your best glasses.

The questions in this questionnaire apply to your situation since the operation, having received your spectacles, if required.

When you answer the questions on the next page you must try to think only of the difficulties that your sight may be causing you. We appreciate that it may be difficult to decide just what your sight means to you if you also have other problems such as joint pains or dizziness for example. We would still ask you to try to answer how important you think your sight is in your ability to perform the following tasks.

When you are asked to state your difficulties, we have given three response options. We call them very great difficulty, great difficulty and some difficulty. Different people may put things differently. Try to see the three response options as three equal size parts of a scale ranging from the greatest to the least difficulty caused by your sight in performing various activities.

An example of how we envisage the scale with the three different response options:

Greatest _____ / _____ / _____least
very great difficulty great difficulty some difficulty

Do you find that your sight at present in some way causes you difficulty in everyday life?

Yes, very great difficulty	Yes, great difficulty	Yes, some difficulty	No, no difficulty	Cannot Decide
☐	☐	☐	☐	☐

Are you satisfied or dissatisfied with your sight at present?

Very dissatisfied	Fairly dissatisfied	Fairly satisfied	Very satisfied	Cannot decide
☐	☐	☐	☐	☐

Do you have difficulty with the following activities because of your sight? If so, to what extent?

In each row place just one tick in the box which you think best corresponds to your situation:

	Yes, very great difficulty	Yes, great difficulty	Yes, some difficulty	No, no difficulty	Cannot Decide
Reading text in Newspapers	☐	☐	☐	☐	☐
Recognising faces of people you meet	☐	☐	☐	☐	☐
Seeing the prices of goods when shopping	☐	☐	☐	☐	☐
Seeing to walk on uneven surfaces	☐	☐	☐	☐	☐
Seeing to do handicrafts, woodwork etc	☐	☐	☐	☐	☐
Reading subtitles on TV	☐	☐	☐	☐	☐
Seeing to engage in an activity/hobby that you are interested in	☐	☐	☐	☐	☐

Note to patient: Please return this form to your optometrist. They will send it back to the hospital where you had your operation.