Cataract Self-Assessment Questionnaire

Section 1: Past eye history

1. Do you currently have, or have you previously had, any other eye conditions?	*Yes*		*No*	
If yes, please give details:				

2. Have you had any previous eye operations including refractive surgery or laser treatment?	*Yes*		*No*	
If yes, please give details:				
Please describe any problems with the operation (if applicable):				

Section 2: Your general health

1. Do you have high blood pressure requiring treatment?		*Yes*		*No*	
If yes:	Are you on treatment?	*Yes*		*No*	
	Is it currently stable?	*Yes*		*No*	

2. Do you have diabetes? *(high blood sugar)*		*Yes*		*No*	
If yes:	Do you take insulin?	*Yes*		*No*	
	Do you take tablets?	*Yes*		*No*	
	Or is it managed by diet?	*Yes*		*No*	
	What is your most recent HbA1C reading (if known)				

3. Do you have angina?	*Yes*		*No*	

4. Have you had a heart attack within the last three months?	*Yes*		*No*	

5. Do you have epilepsy or blackouts	*Yes*		*No*	

6. Do you suffer from head or neck stiffness?	*Yes*		*No*	

7. Do you have recurrent breathing difficulties? *(e.g. severe asthma or chronic bronchitis)*	*Yes*		*No*	

8. Can you walk a single flight of stairs without getting short of breath?	*Yes*		*No*	

9. Can you lie flat for up to 30 minutes?		*Yes*		*No*	
If no:	Is this due to shortness of breath?	*Yes*		*No*	
	Is this due to joint or muscle stiffness?	*Yes*		*No*	

10. Do you suffer from panic attacks or claustrophobia?	*Yes*		*No*	

11. Do you smoke?	*Yes*		*No*	

Section 3: Medicine

1. Do you regularly take any of the following medicines?					
	Heart medicine *(e.g. Digoxin)*	*Yes*		*No*	
	High blood pressure medicine	*Yes*		*No*	
	Steroids	*Yes*		*No*	
	Aspirin	*Yes*		*No*	
	Anticoagulants or blood thinning medicines *(e.g. Warfarin or Clopidrogel)*	*Yes*		*No*	
	Tamulosin (Flomax)	*Yes*		*No*	
	Inhalers	*Yes*		*No*	
	Insulin or blood sugar tablets	*Yes*		*No*	

2. Are you allergic to local anaesthetic?	*Yes*		*No*	

3. Are you allergic to any medicine? If yes, please give details (if applicable)	*Yes*		*No*	

4. Please detail any other medicine/tablets you are taking (or attach a repeat prescription)

Section 4: Practical concerns

1. Are you able to walk unaided?		*Yes*		*No*	
If no:	Can you do so with the aid of a stick or helper?	*Yes*		*No*	

2. If required, would you be able to apply eye drops?		*Yes*		*No*	
If no:	Do you have family or friends who could do so?	*Yes*		*No*	

3. If you need a home visit for the assessment, are you able to travel to the treatment?	*Yes*		*No*	

4. Do you have <u>significant</u> hearing loss?	*Yes*		*No*	
If so, do you require someone who can use sign language to be present?	*Yes*		*No*	

5. Do you require an interpreter?	*Yes*		*No*	
If so, which language do you require the interpreter to speak?				

Section 5: How is the cataract affecting your life?

1. Is your sight causing you any difficulty with mobility *e.g. crossing roads, managing steps, using buses?*	*Yes*		*No*	
2. Do you have problems with glare in sunlight, or from car headlights?	*Yes*		*No*	
3. If you drive, do you still feel confident to do so?	*Yes*		*No*	
4. Is your vision affecting your ability to look after yourself? *e.g. cooking, housework, dressing*	*Yes*		*No*	
5. Is your quality of life affected by visual difficulties? *e.g. reading, watching TV, hobbies, sport*	*Yes*		*No*	
6. Is your vision causing problems socially? *e.g. recognising people, handling coins and notes?*	*Yes*		*No*	

7. How much better do you think your life would be without a cataract?							
A lot?		***Moderately?***		***Slightly?***		***Not at all?***	

Finally

If the eye specialist was to offer you cataract surgery, would you want it at this time?	*Yes*		*No*	