

Cataracts: Quality of Life

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A **cataract** is a clouding of the lens in the eye leading to a decrease in vision. It can affect one or both eyes. Often it develops slowly. Symptoms may include faded colors, blurry vision, halos around light, trouble with bright lights, and trouble seeing at night.^[1] This may result in trouble driving, reading, or recognizing faces.^[2] Poor vision may also result in an increased risk of falling and depression.^[3] This survey has been developed to determine the extent your cataracts effect your everyday life activities. It will help us determine if we should considering proceeding with a procedure to remove the cataract.

Pt Name: _____ Date: _____	Yes: Severity of Effect 1 = trace 2 = mild 3 = moderate 4 = severe	NO
1. Do you think you have a problem with your vision?	1 2 3 4	<input type="checkbox"/>
2. Do you have difficulty reading small print such as a labels on medicine bottles, a telephone book, food labels	1 2 3 4	<input type="checkbox"/>
3. Do you have difficulty Reading a newspaper or a book	1 2 3 4	<input type="checkbox"/>
4. Do you find it difficult to see the TV or reading subtitles?	1 2 3 4	<input type="checkbox"/>
5. Have you had any falls in the street or at your home or seeing step, stairs or curbs (eg, stairs, curbs, uneven ground)?	1 2 3 4	<input type="checkbox"/>
6. Do you have any problems with driving during the day?	1 2 3 4	<input type="checkbox"/>
7. Do you have any problems with night-time driving?	1 2 3 4	<input type="checkbox"/>
8. Have you felt your self altering your activities due to your vision? Taking part in sports like bowling, handball, tennis, golf or playing games such as bingo, dominoes, card games or mah jong	1 2 3 4	<input type="checkbox"/>
9. Do you have any difficulty recognizing faces?	1 2 3 4	<input type="checkbox"/>
10. Are there any hobbies that are made difficult by your poor vision?	1 2 3 4	<input type="checkbox"/>
11. Have you perceived a change to the appreciation of colors and brightness of light?	1 2 3 4	<input type="checkbox"/>
12. Having difficulties in completion of forms or paperwork due to	1 2 3 4	<input type="checkbox"/>

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your vision?		
13. Having difficulties in completing or performing household task, cooking, cleaning... due to your vision.	1 2 3 4	
14. Any other difficulties experienced in regards to your vision?	1 2 3 4	
15. Do you live alone or are others in the household. If there are others in the house: Spouse, Child or Care – Taker.		
16. Are you in a “long term residential community” or nursing facility?		
17. Are you able to administer medications without assistance, including the reading and understanding of directions, taking of oral medications and the ability to place drops in your eye?		
18. Are you able to drive to appointments or do you need assistance.		
19. What other activities do you feel are compromised due to your vision: 1. 2. 3. 4.		
20. Do you feel that your everyday activities and lifestyle are negatively impacted by the limitations of your vision?		

Modified Sample Quality of Life Questionnaire – VF (Visual Function) 12 – 14, plus living situation and ability to self care. ¹ B J Kirkwood, K. Pesudovs, P.Latimer and D. J. Coster The efficacy of a nurse-led preoperative cataract assessment and postoperative care clinic MJA 2006; 184 (6): 278-281 http://www.mja.com.au/public/issues/184_06_200306/kir10534_fm-1.gif

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