BOHN, JOSEPH & SWAN EYE CENTER
PRIMARY & CORNEA EYE CARE IN ACADIANA

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Activities of Daily Living Questionnaire (ADL)

☐ **Right Eye** ☐ **Left Eye**

Patient Name: _____ DOB: _____ Chart ID : _____

*****Please note that if this lifestyle questionnaire is being used to evaluate the condition of your cataracts, it is very important that you indicate any trouble you have noticed to allow cataract surgery to be considered a "covered" expense by Medicare and most insurance companies.*****

1. Do you have problems with blurriness when driving, seeing street signs, or anything at a distance?

   _____ Yes _____ No

2. Do you find that reading small print and doing detailed work is becoming difficult? (Telephone books, medicine labels, sewing, baiting a fish hook)

   _____ Yes _____ No

3. Do you find that colors are not as bright and bold as they once were?

   _____ Yes _____ No

4. Are you bothered by glare, halos, or rings around light?

   _____ Yes _____ No

5. Do you ever stumble or feel off balance when climbing stairs or curbs?

   _____ Yes _____ No

6. If you could decrease your dependence on glasses but your insurance would only offer partial payment, would this be something you would be interested in learning more about?

   _____ Yes _____ No

Patient Signature _____ **Date** _____