# Cataract Self-Assessment Questionnaire

| Patient's details | Optometrist details |
|---|---|
| *First name:* | *Optometrist:* |
| *Last name:* | *Practice:* |
| *Address:* | |
| *DOB:* | **GP details** |
| *Phone:* | *GP name:* |
| *Mobile:* | *Practice:* |
| *Email:* | |
| *NHS number:* | *Code:* |

This form is designed to help you have your cataract treated in the best way possible.

Please complete **ALL** the sections. If you are unable to provide any of the information, please ask a member of your family or a friend to help.

If you have any problems completing the form, the optometrist will help you. Please bring details of all your medication with you (either a repeat prescription list or the medicines themselves.)

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

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|---|---|---|---|---|---|
| **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* | |

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|---|---|---|---|---|---|
| **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) | | | | |

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

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

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

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

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

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

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|---|---|---|---|---|---|
| **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* | |

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

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

# Section 3: Medicine

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|---|---|---|---|---|
| **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/Clopidrogel)* | *Yes* | | *No* |
| | Tamulosin (Flomax) | *Yes* | | *No* |
| | Inhalers | *Yes* | | *No* |
| | Insulin or blood sugar tablets | *Yes* | | *No* |

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

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|---|---|---|---|---|
| **3. Are you allergic to any medicine?** | *Yes* | | *No* | |
| *If yes, please give details:* | | | | |
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| **4. Please detail any other medicine/tablets you are taking (or attach a repeat prescription)** |
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# Section 4: Practical concerns

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|---|---|---|---|---|---|
| **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* | |

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| **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* | |

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

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| **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* | |

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|---|---|---|---|---|
| **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?

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|---|---|---|---|---|
| **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?** | | | |
| | Please tick one: | ***A lot?*** | | |
| | | ***Moderately?*** | | |
| | | ***Slightly*** | | |
| | | ***Not at all?*** | | |

# Finally:

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|---|---|---|---|---|
| **1.** | **If the eye specialist was to offer you cataract surgery, would you want it at this time?** | *Yes* | | *No* |

In order to provide you with the most appropriate care, it will be necessary for the optometrist to exchange information relating to your cataract with your GP and the eye clinic. It may also be necessary for the eye clinic to provide information to your optometrist. Any information that is sent or received will be kept securely and will remain confidential.

Signed……Date……