Understanding Cataracts

What is a cataract?

If you have a cataract, it means that the lens in your eye has become cloudy. We're all born with a lens inside each of our eyes. The lens helps to focus light inside the eye so we can see. Over time, the lens becomes cloudy and interferes with vision.

Here are some things you may notice if you have cataracts:

- Glare around lights at night
- Trouble reading in dim light
- Colors seem dull
- Double vision out of the eye(s) with the cataract
- General poor quality of vision

In the early stages of a cataract the changes may not be noticeable. Very advanced cataracts can cause near-total blindness.

What causes cataracts?

Most cataracts develop over time as natural changes in the lens in the eye. The regular arrangement of proteins in the lens becomes disrupted, causing the lens to become cloudy. Sometimes, cataracts are the result of injury, steroid medication use, prior eye surgery, or other causes.

What can be done to prevent cataracts?

Usually there is nothing you can do to prevent cataracts. Everyone who lives long enough will develop cataracts. Some things will make them develop faster, such as smoking, steroid use, and injury, and avoiding these things, if possible, may delay the age at which you develop cataracts.

Will I go blind from cataracts?

Cataracts are reversible with surgery. If left untreated, vision can decline to the point of blindness, but even then it is usually possible to perform surgery and restore vision.

If I have cataracts, do I need surgery right away?

With very few exceptions, correcting cataracts with surgery is not an emergency. Most patients can wait years, and even decades, before needing surgery. In the early stages, cataracts will often change the prescription in your glasses, so just getting a new pair of glasses may make your vision better. Eventually, new glasses will not help enough, and surgery may be needed to correct the cataract.

When should I have cataract surgery?

In most cases, it is best to have surgery when you are bothered by your vision, and the cataract is causing you some problem in your daily life. People with significant cataracts often have trouble with night driving, seeing the television, reading, or other visual tasks. If everything seems fine with your vision, you usually do not need cataract surgery. As the cataract develops, you will notice that your vision declines, and that you have difficulty seeing well enough to do the things you need to do and the things you enjoy. When the cataract interferes with your life in this way, you should consider surgery.

Is there a medicine or nutritional supplement that I can take instead of having surgery?

No. Currently there is no known medical treatment for cataracts. New glasses will often make your vision better as the cataracts develop, but eventually the only treatment option is surgery.

How is cataract surgery performed?

Your cataract surgery will be a scheduled procedure in an operating room. During surgery, your surgeon will remove the cloudy lens and replace it with an artificial plastic one. You will receive anesthetics to prevent discomfort and make you relaxed.

Does it hurt?

Usually there is no pain with cataract surgery. In many cases you may not even remember the procedure after it is performed. After the surgery, your eye may be red and feel scratchy or feel like something is in it.

Is it done with laser?

There are various ways to remove a cataract. An ultrasound probe is used to break up and remove the cataract in most cases. A laser can be used for some of the procedure to break up the cataract and help to decrease astigmatism. In cases of very advanced cataracts, the

procedure is sometimes done manually, where the cataract is removed as one piece through a larger incision. The choice of technique is something you can discuss with your surgeon prior to the procedure.

Is cataract surgery safe?

No surgery is completely risk-free, but modern cataract surgery has a very high success rate. The vast majority of patients do very well, and enjoy significant improvement in their vision. Complications, while rare, can happen. When complications occur, it is usually possible to recover from them and still achieve good vision, although not in all cases.

What are the risks of cataract surgery?

Like all surgeries, cataract surgery has risks. You should weigh these risks against the potential benefits of the surgery in deciding whether to undergo it. Common, less serious risks include blurred vision or discomfort for a few days after surgery, a dark area in your peripheral vision, floaters, sensitivity to bright lights, increased eye pressure, or a droopy eyelid. More serious risks are rare, but it is possible to have a complication that permanently impairs your vision, or requires additional surgery or medical treatments to correct. These include rupture of the capsule that holds the natural lens, infection, detachment of the nerve layer inside the eye (the "retina"), swelling of the retina, or permanent swelling of the clear dome over the surface of the eye (the "cornea"). Fortunately, most patients do not experience these things, and do very well with their surgery.

Are there any guarantees?

No. You and your surgeon will work together as a team to try to get you the best vision possible, but there are no guarantees as to a particular outcome for your surgery.

Will I be glasses-free after my surgery?

Cataract surgery is an exciting opportunity to change the optics in your eyes and refocus them. In many cases it is possible to correct nearsightedness, farsightedness, and astigmatism at the time of surgery. This is done by choosing an appropriate lens to implant at the time of surgery, and deciding whether to use a laser or not. If you are interested in trying to decrease your dependence on glasses after surgery, you should discuss this with your surgeon before the operation. There are some lens implants that are specifically designed to reduce your dependence on glasses after surgery. Some, but not all of these lenses have extra charges that are not covered by your insurance. It is important that you consider your choices before the surgery, because the lens you have implanted will be with you for the rest of your life.

Is surgery covered by insurance?

Cataract surgery is covered by almost all medical insurance plans, including Medicare, as long as you meet certain criteria for visual disability. It is not usually covered by "vision" plans. You may be responsible for co-pays for the surgery, including for the facility fee and/or anesthesia services. In addition, if you select a specialty lens (such as astigmatism-correcting lenses or multifocal lenses) or require non-standard additional services, such as laser catatact surgery, there may be charges for these. You should ask the surgical coordinator for an estimate of these charges prior to surgery.

If I decide to have cataract surgery, how do I schedule it?

To schedule cataract surgery, let your surgeon know that you would like to proceed. The surgical coordinator at the practice will get you a date for preoperative testing and for the surgery, and will arrange the logistics of the procedure.

What if I have other questions about the cataracts?

You should ask your physician if you have other questions about cataracts, particularly if you are considering surgery. You should never decide to have cataract surgery if you do not feel fully informed.

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SURGERY CENTER EAST

CONTACTS FOR PATIENT BILLING

Your physician may prescribe any of the following services or supplies as an integral part of your surgical experience. For your convenience, Constitution Surgery Center East, LLC contracts with the following companies to make these supports available onsite.

The following companies are contracted with many insurance companies and insurance plans, but the insurance company cannot guarantee that your specific plan covers all the costs. You are ultimately responsible for payment in full for these products or services.

Medicare pays 80% with a 20% co-insurance after deductible. All other insurances have varying coverage percentages. Please refer to your insurance policy.

The self-pay rate for the surgical center includes the facility fee and a standard intraocular lens for your cataract surgery. If your doctor recommends a specialty lens, a separate fee is associated with that lens. The physicians' office will inform you of the fees for the Surgical Center. These fees will be separate from your physician's fee and anesthesia's fee.

Constitution Surgery Center East, nor the physician, has any ownership or financial interest in the following companies. Please contact the respective companies directly for any questions or concerns regarding billing.

Anesthesia Services: End date 7/15/22	Anesthesia Associate of New London/ Envision	1-844-248-4320
Anesthesia Services: Start date 7/18/22	Anesthesiologists of Middletown	1-860-347-0720
Pathology: *(Lab testing)*	Quest Diagnostics	1-888-277-8772
Pneumatic leg compression devices:	Precision Medical Products	1-888-963-6265
Orthopedic supplies: *(knee braces, crutches, slings, etc.)*	Surgi-Care	1-888-290-8905

Prior to your surgical procedure, a representative from CSCE may contact you regarding your financial responsibility to the surgery center. We take all major credit cards and participate with ePay Healthcare. If financial arrangements need to be made, please contact CSCE billing at 1-888-252-7870 ext. 301.

140 Cross Rd, Waterford CT 06385
Ph# 860-701-0140 Fx# 860-701-0161

Pre Screening Cat Eval Questions

NAME:_____**DOB**_____ **TODAYS DATE**_____

Latex Allergy	**Yes**	**No**	**MRSA (Staph infection)**	**Yes**	**No**
ICD (Defibrillator)	**Yes**	**No**	**Date:**_____**Body part:**_____		
Diabetic Oral Meds	**Yes**	**No**	**Van Service**	**Yes**	**No**
Diabetic Insulin	**Yes**	**No**	**Wheel Chair Van**	**Yes**	**No**

Do you wear Contact Lens	**Yes**	**No**	**If yes, No CL's 3 days prior to preop and surgeries for Soft lens**
Soft Lens	**Yes**	**No**	
Hard Lens	**Yes**	**No**	**No CL's 3 Weeks prior to preop and surgeries for Hard lens**

Oxygen Use	**Yes**	**No**	
Do you take Prostate meds (Such as Flomax)	**Yes**	**No**	
Stroke	**Yes**	**No**	**Date:**_____
Heart Attack	**Yes**	**No**	**Date:**_____
A-Fib	**Yes**	**No**	**How long have you had it?**_____
Recent Hospitalization with Admission	**Yes**	**No**	**Date:**_____ **Reason:**_____
Aneurysm	**Yes**	**No**	**Size:**_____
Previous Refractive Surgery (Lasik,PRK)	**Yes**	**No**	
Other Eye Surgery Please List Eye and SX below	**Yes**	**No**	

Patient's Signature_____ **Date** _____

Southeast Connecticut Eye Care LLC
Kevin Cranmer, MD
William Kaufold, MD
SEE-CARE.com
860-373-4148

Cataract Patient Scheduling Information

Patient name:_____

Appointment Type	Date	Time	Location
Preop			
Surgery		TBD	Waterford
1 Day postop			
Surgery		TBD	Waterford
1 Day postop			

Complete all paperwork prior to your preoperative appointment.

Contact lens wearers – No contacts 3 days prior to preop and surgeries for soft lens and 3 weeks for hard lens.

The surgery center will call you one or two business days prior to your surgery to let you know what time to arrive.

Our office locations are:

- Norwich: 12 Case Street, Suite 215, Norwich
- Groton: Groton Eye Center, 1041 Poquonnock Road, Groton
- Willimantic: Tri-County Vision Associates, 16 Walnut Street, Willimantic
- Danielson: Killingly Eye Care, 25 Green Hollow Road, Danielson

Surgery Center location:

Constitution Surgery Center East, 140 Cross Road, Waterford, CT 06385
860-701-0140

Constitution Surgery Center East

140 Cross Road | Waterford, CT 06385 | 860-701-0140

Patient Medical History

Name: _____ Date of Birth: _____ Gender: M or F

Phone Number: _____ Language: _____ Height: _____ Weight: _____

Surgeon: _____ Primary Care Doctor: _____ Phone: _____

Cardiologist: _____ Phone: _____ Pulmonologist: _____ Phone: _____

Person Completing this Form: _____ Relationship: _____

Do you have ALLERGIES and/or SENSITIVITIES? ☐ Y ☐ N **If yes, please LIST BELOW**

(i.e. LATEX, medication, tape, metal, contrast dye, Iodine, food, environmental)

Allergy	Reaction

Please List Any Surgeries You Have Had:

Surgery	Date

- Have You Ever Had a Problem With Anesthesia? ☐ Y ☐ N

  If Yes, Explain _____

- Have You or a Blood Relative Had a Reaction to Anesthesia Called Malignant Hyperthermia? ☐ Y ☐ N

  If Yes, Please Specify Who? _____

List Home Medications or attach a copy of your medication list.

Include all prescription medications, over the counter medications and herbal products.

Medication Name	Dose	How often?	Reason for taking

PATIENT NAME:_____ DATE OF BIRTH:_____

Health History

Place a mark (X) if you have any of the following

Neurological Problems ( ) None

( ) CVA/Stroke *date*_____
( ) TIA/Mini stroke *date*_____
( ) Seizures *most recent* _____
( ) Restless Leg Syndrome
( ) Other *Specify* _____

Pulmonary Problems ( ) None

( ) COPD/Emphysema ( ) Asthma
( ) Shortness of breath ( ) Use oxygen *liters*____
( ) Sleep apnea ( ) Recent Cold
( ) CPAP/BIPAP machine
Machine settings _____
( ) Other *Specify* _____

Cardiac Problems ( ) None

( ) High blood pressure ( ) Congestive heart failure
( ) Elevated cholesterol ( ) Heart murmur
( ) Angina (heart chest pain) ( ) Leaky valve
( ) Coronary artery disease ( ) Valve prolapsed
( ) Angioplasty/stents ( ) Blood clot in leg
( ) Heart attack *when?* _____
( ) Swelling in legs/feet/PVD
( ) Irregular heart beat
( ) Pacemaker *when?* _____
Company? _____
( ) Defibrillator: *when?* _____
Company? _____
( ) Other *Specify* _____

Genitourinary Problems ( ) None

( ) Prostate Problems ( ) Peritoneal dialysis
( ) Hemodialysis *Days* _____
( ) Other *Specify* _____

Gastrointestinal Problems ( ) None

( ) Hepatitis *type* _____ ( ) Liver disease
( ) Heartburn ( ) Peptic Ulcer
( ) Other *Specify* _____

Endocrine Problems ( ) None

( ) Thyroid Problems
( ) Diabetes How long? _____
( ) Other *Specify* _____

Musculoskeletal Problems ( ) None

( ) Disk problems ( ) Chronic Pain Syndrome
( ) Cane/Walker/Wheelchair ( ) Arthritis
( ) Other *Specify* _____

Hematological (Blood) Problems ( ) None

( ) Anemia ( ) Clotting problems
( ) Bleeding Problems
( ) Other *Specify* _____

Psychiatric History ( ) None

( ) Depression ( ) Panic/Anxiety Attacks
( ) Bipolar ( ) Schizophrenia
( ) ADD ( ) Mentally Challenged
( ) Other *Specify* _____

Infectious Disease ( ) None

( ) Recent Exposure to Communicable Disease
( ) HIV Positive ( ) Infection Called C DIFF
( ) Infection Called MRSA ( ) Infection Called VRE
( ) Have RECENTLY had a Fever, Night Sweats, Cough, Bloody Sputum or Fatigue for More Than 3 WEEKS
( ) Other *Specify* _____

Social History ( ) None

( ) Tobacco Use *How much/often?* _____
Or, When did you quit? _____
( ) Alcohol Use *How much/often?* _____
( ) Recreational drug use *Type?* _____
How much/often? _____
( ) Have a Health Care Proxy/Durable Power of Attorney for Health Care or Conservator *Who?* _____
( ) Other *Specify* _____

Eye, Ear, Nose, Throat Problems ( ) None

( ) Glasses ( ) Contact Lenses
( ) Legally blind ( ) Prosthetic Eye R L
( ) Hearing Aids R L ( ) Dentures
( ) Sign Language ( ) Need Interpreter
( ) Other *Specify* _____

Female ONLY

( ) Pregnant *due date* _____

Last menstual period _____

Constitution Surgery Center East
140 Cross Road | Waterford, CT 06385 | 860-701-0140

Medication List

List Home Medications or attach a copy of your medication list.

Include all prescription medications, over the counter medications and herbal products.

If you need additional space for your medications, please use the space below.

Medication Name	Dose	How often?	Reason for taking

CONSTITUTION
SURGERY CENTER EAST

Patient's name: _____ DOB:_____ Date of Surgery: _____

INFORMED CONSENT FOR SURGERY

Please initial each numbered item to acknowledge your agreement with it.

_____1.) **PROCEDURE:** I voluntarily consent to the following surgical procedure to be performed by Dr.Cranmer and/or his associates or assistants, as he may deem necessary or appropriate. My doctor *(or associates)* has explained to my satisfaction the nature, purpose and potential benefits of the operation. I have been informed of the prognosis if no treatment is provided and of the possible alternative treatment plans.

Cataract Surgery with Intraocular Lens Implant:	**☐RIGHT EYE**	**☐LEFT EYE**

_____ 2.) **CONSENT TO TREATMENT OF UNFORESEEN CONDITIONS:** I understand that conditions may arise at the time of surgery which are unforeseen at this time and that it may be necessary or advisable to perform operations/procedures different from or in addition to the procedures described. I authorize and consent to the performance of such additional or different operations/procedures as my doctor considers necessary or advisable. I understand that it may be necessary to test my blood while I am a patient in an effort to protect against possible transmission of blood-borne diseases such as Hepatitis B or Acquired Immune Deficiency Syndrome. If, for example, an employee is stuck by a needle or scalpel while administering care to me, I understand that my blood, as well as the employee's blood, will be tested. I have been informed that the performance and results of the HIV antibody test are considered confidential. The test results in my health record shall not be released without my written permission, except to individuals and organizations that have been given access by law who are required to keep my health record information confidential.

_____3.) **MATERIAL RISK/POSSIBLE COMPLICATIONS:** As with any surgical procedures, there are risks related to the performance of the surgery planned for me. I realize that common risks of surgical procedures include, but are not limited to, the potential for infection, blood clots, hemorrhage, allergic reactions, nerve injury, vascular injury and even death. I also realize that the following additional **RISKS** in connection with the planned procedures include, but are not limited to:

1. Inflammation or infection
2. Loss of corneal clarity
3. Detachment of the retina
4. Increase in eye pressure
5. Irregular or dilated pupil
6. Double vision
7. Vision could be worse
8. Total loss of vision
9. Loss of eye
10. Retained particles of the cataract
11. Displacement or dislocation of the intraocular lens
12. Swelling of the retina
13. Foreign body sensation
14. Light sensitivity
15. Nighttime glare
16. Droopy eyelid
17. Need for more surgery
18. Need for glasses or contact lenses
19. Clouding of the tissue behind the implant

_____4.) **ANESTHESIA:** I consent to the administration of such anesthetics as appropriate or advisable for my surgical procedure and physical condition. In some instances, introduction of local anesthesia is accomplished by introducing a needle or cannula into the orbit surrounding the eye in order to make the eye insensitive to the operative procedure. The risks of this procedure, although rare, can be serious and include injury to the eye itself and the muscles surrounding the eye. Such injuries can lead to visual impairment or total loss of vision. Alternatives to periorbital injection, including sedation in combination with eye drops or numbing gel have been discussed. The appropriateness of which type of anesthesia is used is dependent upon the surgery in question, the requirements of the surgeon and other patient health issues.

_____ 5.) **PATHOLOGY/LABORATORY SPECIMENS:** I consent to the preservation or use for medical, diagnostic, scientific or teaching purposes, or disposal by the surgical facility of any tissues, fluids, or body parts (including pathology specimens or laboratory testing) removed during the course of my operation.

_____6.) **PHOTOGRAPY:** I consent to photography and/or video of the area involved in the surgery. The photography and/or video will be done for medical reasons only related the surgery.

_____7.) **DRIVING AN AUTOMOBILE:** I understand that it is my responsibility, and I have arranged for a responsible adult to drive me. I acknowledge that I have been instructed not to drive until the effects of any medication have worn off. I understand this to mean that I should not drive until the day after my surgery/procedure or as directed by my physician.

Patient's name: _____ DOB:_____ Date of Surgery: _____

_____8.) I have had sufficient opportunity to discuss my condition and the operation or medical treatment with my doctor or his associate*(s)*. All my questions have been answered to my satisfaction. I understand the operation or medical treatment I will receive.

_____9.) I understand that observers, including students, other medical professionals, industry representatives, or others as allowed by my physician may be present in the operating room during my surgery in an observer capacity only. I consent to the presence of these individuals.

_____10.) I acknowledge I have received, reviewed, and read Constitution Surgery Center East's (CSCE's) policy on Advance Directives.

_____11.) I acknowledge I have received, reviewed, and read CSCE's Patient Bill of Rights.

_____12.) I acknowledge that I have been informed my Physician is an owner of CSCE.

_____13.) I ACKNOWLEDGE THAT NO GUARANTEE OR PROMISE HAS BEEN GIVEN TO ME BY ANYONE AS TO THE RESULTS THAT MAY OCCUR FROM THE OPERATION OR MEDICAL TREATMENT DESCRIBED IN THIS CONSENT. I HAVE READ THIS DOCUMENT, IN ITS ENTIRETY OR THIS DOCUMENT HAS BEEN READ TO ME AND I FULLY UNDERSTAND IT.

Signature of the Patient/ Relative/ Legal Guardian:	**Date:**
Printed name of Patient/ Relative/ Legal Guardian:	Relationship to Patient:
Signature of Reader *(if necessary)*:	Printed name of Reader:
Witness Signature:	Date:
Print name of Witness:	Date:

DOCTOR'S CERTIFICATION

I have explained to the patient, relative or guardian, the nature, purpose, potential benefits, complication, substantial risks of and alternatives *(if any)* to the operation or medical treatment described in this consent. I have offered to answer any questions of the patient, relative, or guardian and have answered all such questions. I believe that the patient, relative, or guardian understands the risks and what I have explained.

Additional Doctor Comments:	
Signature of Provider:	Date:
Printed name of provider:	

CONSTITUTION
SURGERY CENTER EAST

Patient's name: _____ DOB:_____ Date of Surgery: _____

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Cataract Surgery with Intraocular Lens Implant:	**☐RIGHT EYE**	**☐LEFT EYE**

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11. Displacement or dislocation of the intraocular lens
12. Swelling of the retina
13. Foreign body sensation
14. Light sensitivity
15. Nighttime glare
16. Droopy eyelid
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Additional Doctor Comments:	
Signature of Provider:	Date:
Printed name of provider:	

Southeast Connecticut Eye Care, LLC

Lens Choices

Your surgeon will usually implant a plastic lens to replace your cloudy natural lens during cataract surgery. You may choose the type of lens implant. Your choice may influence how dependent you are on glasses after your cataract surgery.

Please choose one of the following options **(check or circle one clearly)**:

1. I would like to try to reduce my dependence on glasses as much as possible. I would like to discuss with my surgeon lens choices that can reduce my dependence on glasses and contact lenses. I understand that there may be additional charges for these implanted lenses that are not covered by insurance and that I will have to pay. These charges can range from nothing to several thousand dollars per eye.
2. I would like to have the standard single-focus lens implanted in my eye(s) at the time of surgery, focused as much as possible at far distance. I understand that these lenses do not correct astigmatism, and if I have significant astigmatism I may need glasses at all times. I prefer not to pay anything beyond usual co-pays and other charges for the surgery. I understand I will need glasses for at least some activities after surgery.

If you are unsure, choose option 1. There is no obligation. For more information regarding lens choices, please visit our website at SEE-CARE.com.

Print name Signature Date

Southeast Connecticut Eye Care LLC

Premium/specialty Lens Pricing and Terms

There are additional charges for some types of lenses used for cataract surgery. These lenses are often referred to as “premium” or “specialty” lenses. Medical insurances (including Medicare and Medicaid) do not pay for these lenses.

If you choose one of these lenses, payment is due one week prior to your surgery date. Your surgery may be canceled if we do not receive payment in full prior to surgery.

Premium/specialty lenses include:

Lens	Price per lens
Astigmatism-correcting (toric) single focus lens	$1,600.00
Multifocal lens	$2,600.00
Multifocal astigmatism correcting lens	$2,600.00

There is no additional charge for single focus lenses that do not correct astigmatism (“standard lenses”). Insurance normally covers these lenses as a part of cataract surgery.

By signing below, you acknowledge receipt and understanding of the above information, and your personal responsibility for payment of charges for premium/specialty lenses, if any.

Patient name Signature Date

Southeast Connecticut Eye Care, LLC

Co-management of Surgery

Many patients choose to have their surgeries “co-managed.” With co-management, your surgeon and your usual eye doctor both participate in your post-operative care. This means that your regular eye doctor would see you for some of your post-operative visits. This can have some advantages over seeing your surgeon exclusively:

- Convenience: It may be more convenient to see your usual eye doctor and may involve less travel time.
- Better communication: By involving your usual eye doctor in your post-operative care, (s)he may be better informed about your progress.
- Preference: You may prefer to see your usual eye doctor, whom you’ve seen many times, and who knows you well.

If you choose co-management, you should know the following:

- You can see either your surgeon or your usual doctor whenever needed after surgery.
- You can call either physician if you have a problem after surgery.
- The decision to co-manage is yours. You do not have to co-manage your surgery.
- Your usual physician receives a portion of the surgical fee for doing so. There are no extra charges if you elect co-management of your surgery.

If you choose to co-manage your surgery, please sign below.

Choose one (check or circle one clearly):

I understand surgical co-management and elect this option.

I prefer no co-management of my surgery.

Printed name Signature Date

INSURANCE CATARACT SURGERY QUESTIONNAIRE

Patient Name _____ DOB_____

Does the member, even with glasses have difficulty with the following activities :

1. Reading small print such as labels on medicine bottles , telephone book, for food labels?
   - Great Deal
   - Moderate
   - Little
   - No Difficulty

2. Reading Newspaper or a book ?
   - Great Deal
   - Moderate
   - Little
   - No Difficulty

3. Reading Large print book or large print newspaper or numbers on telephone?
   - Great Deal
   - Moderate
   - Little
   - No Difficulty

4. Recognizing people when they are close to you?
   - Great Deal
   - Moderate
   - Little
   - No Difficulty

5. Seeing Steps, Stairs, Curbs?
   - Great Deal
   - Moderate
   - Little
   - No Difficulty

6. Reading Traffic Signs , Street signs , or store signs?
   - Great Deal
   - Moderate
   - Little
   - No Difficulty

7. Doing Fine handiwork like sewing, knitting, crocheting or carpentry?
   - Great Deal
   - Moderate
   - Little
   - No Difficulty

8. Writing Checks or filling out forms?
    Great Deal
    Moderate
    Little
    No Difficulty

9. Playing Games such as bingo, domino's, card games?
    Great Deal
    Moderate
    Little
    No Difficulty

10. Taking part in sports like bowling, handball, tennis or golf?
    Great Deal
    Moderate
    Little
    No Difficulty

11. Cooking?
    Great Deal
    Moderate
    Little
    No Difficulty

12. Watching Television?
    Great Deal
    Moderate
    Little
    No Difficulty

13. Driving during the day?
    Great Deal
    Moderate
    Little
    No Difficulty

14. Driving during the night?
    Great Deal
    Moderate
    Little
    No Difficulty

Signature of patient _____

Date_____