Dear Patient,
Your lifestyle, as well as your personal vision requirements and expectations are all important factors to consider when selecting an appropriate intraocular lens (IOL) for your cataract surgery. Please answer the following questions to help us choose the right treatment option for you.

1 **Please insert your personal data:**

Name: Age: Profession:

2 **What hobbies / leisure activities do you pursue?**

3 **How many hours do you spend on these activities every day?**

○____Computer work	○____Reading	○____Watching TV	○____Garden work
○____Fine handwork	○____Driving	○____Cooking	○____Shopping
○____Playing chess / cards	○____Walking	○____Biking	○____Other

4 **How good is your vision without glasses for the following distances and conditions?**

a) Close distance (reading fine print)	○ very good	○ good	○ poor	○ very poor
b) Intermediate distance (computer work)	○ very good	○ good	○ poor	○ very poor
c) Far distance (driving)	○ very good	○ good	○ poor	○ very poor
d) Dim light (at night)	○ very good	○ good	○ poor	○ very poor

5 **Do you currently wear glasses and, if yes, for what distances / activities? (please choose all relevant answers)**

○ Yes, for close distance (reading fine print).
○ Yes, for intermediate distance (computer work).
○ Yes, for far distance (driving).
○ No, currently I do not wear glasses.

6 **What kind of glasses do you have?**

○ Progressive spectacles
○ Bifocal spectacles
○ Different types of spectacles (each one for a different distance)
○ I do not know what type of glasses I have.

7 **Does it bother you to wear glasses?**

○ Yes, wearing glasses bothers me a lot.
○ In some situations – I would prefer not having to wear glasses the whole time.
○ No, I do not mind wearing glasses at all.

8 **How important is it for you NOT to have to wear glasses for the following distances / activities after surgery:**

a) Seeing up close (reading, fine handwork)

○ very important ○ quite important ○ not so important ○ completely unimportant

b) Intermediate vision (computer work, shopping, cooking)

○ very important ○ quite important ○ not so important ○ completely unimportant

c) Seeing in the distance (driving, sports)

○ very important ○ quite important ○ not so important ○ completely unimportant

9 **Which statement best describes your vision requirements at night:**

○ Good vision is very important to me in all light conditions.
○ I stay up late performing different activities such as driving so I need good vision also at night.
○ I am not very active at night, so my night vision does not need to be perfect.

10 **Do you experience any disturbing light phenomena at night such as light reflections, dazzle, etc.?**

○ Yes, very often ○ From time to time ○ No, never ○ I am not sure

11 **How do you react to light phenomena at night such as light reflections, dazzle, etc.?**

○ I am very sensitive to all light phenomena, I find them very disturbing.
○ The night light phenomena annoy me.
○ I can tolerate light phenomena quite well.
○ Light phenomena do not bother me at all.

12 **Please choose the statements that best describe you as a person (tick all that apply)**

○ I do a lot in my spare time.
○ I like spotting and correcting mistakes.
○ I always know where I have put my personal things like keys, glasses or my mobile phone.
○ I set high standards for myself and others.
○ I enjoy talking to my friends and family.
○ I don't like compromises: I always go for the best.
○ I am very well informed about medical topics.