APPENDIX

3.1 Cataract Audit – Patient "TyPE Questionnaire"

Please answer these questions based on your best vision with both eyes open and wearing glasses or contact lenses if you usually do.

1. **How would you rate your vision? (how well do you see?).** *Please circle one number*

Poor	1
Fair	2
Good	3
Very Good	4
Excellent	5

2. **How much does your vision hinder, limit, or disable you in each of the following activities?** *Please circle one number on each line*

Activity	*Not at All*	*A little bit*	*Some*	*Quite a lot*	*Totally disabled*	*Don't do for other reasons*
Your usual daily activities	1	2	3	4	5	0
Recognising people or objects across the street	1	2	3	4	5	0
Reading price labels in shops or supermarkets	1	2	3	4	5	0
Reading a magazine, newspaper or book	1	2	3	4	5	0
Knitting or sewing	1	2	3	4	5	0
Watching television	1	2	3	4	5	0
Daytime driving	1	2	3	4	5	0
Night-time driving	1	2	3	4	5	0

3. **How much are you hindered, limited, or disabled by glare (dazzling light) in each of the following activities?**
Please circle one number on each line

Activity	*Not at All*	*A little bit*	*Some*	*Quite a lot*	*Totally disabled*	*Don't do for other reasons*
Your usual daily activities	1	2	3	4	5	0
Reading shiny paper (such as a magazine)	1	2	3	4	5	0
Driving towards the sun or oncoming headlights	1	2	3	4	5	0
Walking outside on a sunny day	1	2	3	4	5	0

4. **Who filled in this form?** *Please circle one number*

I filled it out with no help	1
I filled it out with help with from family and friends	2
I filled it out with help from a nurse or doctor	3
Family and friends filled it out	4
A nurse or doctor filled it out	5

5. **Have you had a recent illness, injury, or emotional upset that has affected how you answer these questions?**

Yes	1
No	2

POST-OPERATION/AFTER-OPERATION ONLY

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6. **How satisfied are you after your surgery.** *Please circle one number*

Very Satisfied 1 Fairly Satisfied 2 Rather Dissatisfied 3 Very Dissatisfied 4