Life le Q e ionnai e

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Patient Name:_____ Date:_____

If it is determined that surgery is appropriate for you, this questionnaire will help us provide the best treatment for your visual needs. It is important that you understand that many patients still need to wear glasses for some activities after surgery. Please fill this form out completely and turn in to your technician. Please do not hesitate to contact us with any questions.

1. After surgery, would you be interested in seeing well **i ho gla e**