

Date: _____

Name:	D.O.B
Reason for Today's Visit:	
Do You Smoke? Yes No	Occasionally
Drink Alcohol? Yes No	Occasionally
	esage of any/all medications, eye drops, and/or y basis: (Include any blood thinners, ie: Aspirin,
Name	Dosage
Please list all alleraies related	d to food, medications, latex:
3	,



Check any of the following conditions that apply to you: ___ High Blood Pressure ___ Kidney ___ Cough ___ Stroke ___ Fatigue ___ Prostate ___ Cholesterol ___ Autoimmune ___ Respiratory ___ Neurological ___ Anxiety HIV/AIDs ___ Thyroid ___ Cancer ___ Gastrointestinal ___ Psychiatric ___ Heart ___ Depression ___ Hepatitis ___ Blood abnormalities ___ Tuberculosis ___ Diabetes: (circle) Type 1 Type 2 Eye Conditions: ___ Cataracts ___ Glaucoma ___ Macular Degeneration ___ Dry Eye Any other eye/medical conditions not mentioned above: ______ Eye Surgery History: _____



General Surgery History:		
3 , ,		
Family Eye History:	 	
Family Medical History:		
. a		

Cataract Surgery Pre-Op Questionnaire

Patient Name:	Date:
Do you have difficulty, even with glass	es, with the following activities?

Reading small print, such as labels on medicine bottles or food labels?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ Unable to do the Activity
2. Reading a newspaper or book?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ Unable to do the Activity
3. Seeing steps, stairs, or curbs?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ Unable to do the Activity
4. Reading traffic, street, or store signs?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ Unable to do the Activity
5. Doing fine handwork, like sewing, knitting, crocheting, or carpentry?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ Unable to do the Activity
6. Writing checks or filling out forms?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ Unable to do the Activity
7. Playing games, such as bingo, dominos, or card games?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ Unable to do the Activity
8. Watching television?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the Activity

Cataract Surgery Pre-Op Questionnaire

Are you bothered by any of the following **symptoms**?

1. Hazy and/or blurry vision? Difficulty focusing?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ Unable to do the Activity
2. Poor night vision or difficulty seeing in dim light?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ Unable to do the Activity
3. Glare, halos, or streaks around lights?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ Unable to do the Activity
4. Glare from car headlights or bright sunlight?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ Unable to do the Activity
5. Always feeling like you need to clean your glasses?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A Moderate Amount ☐ Unable to do the Activity
Patient Signature:	Date:

VISION FOR YOUR LIFESTYLE.

SURVEY FOR CATARACT PATIENTS

You have an important decision to make about your vision future.

This survey is designed to help us understand your vision goals so we can provide you with the best possible lens for your lifestyle.

1

Throughout the day, you perform activities that require your eyes to focus at different distances.

Circle or write in the activities that are most important for your lifestyle:

DISTANCE









OTHER

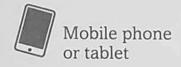
INTERMEDIATE



a dashboard







OTHER

NEAR



Fine print







Driving _	Engaging in lifestyle activities (i.e. golf, gardening, cooking, etc.)	Using media devices (i.e. mobile phone, tablet, e-reader)	Reading books, newspa	rea
Thinking lon	g-term, how importan	it is it that you re	ly on you	ur glasses less
☐ I don't mir	nd 🔲 It'd be nice		ses are lying	☐ I hate wearing
How often d	o you drive in low-ligh	t conditions (dus	k, night,	dawn, rain)?
☐ Never	☐ Not often,		sionally	☐ Often
-	but I'd like		fits on th	
As best you of the best you of			fits on th	is scale. Perfection
Easygoing I know that is cover some of to learn about	my insurance may only of the procedure, and I	personality type If my property want by insure the second	ocedure rance, I w	Perfection is not fully covant to learn a
Easygoing I know that is	can, mark where your my insurance may only of the procedure, and I	personality type If my property want by insur	ocedure rance, I w	Perfection is not fully covant to learn a