The Witlin Center for Advanced Eyecare

Date: _____

Name: _____ D.O.B. _____

Reason for Today's Visit: _____

_____

Do You Smoke? Yes No Occasionally

Drink Alcohol? Yes No Occasionally

Please list the names & dosage of any/all medications, eye drops, and/or vitamins you take on a daily basis: (Include any blood thinners, ie: Aspirin, Coumadin, Aleve, etc.):

Name	**Dosage**

Please list all allergies related to food, medications, latex: _____

_____

_____

The Witlin Center

for Advanced Eyecare

Check any of the following conditions that apply to you:

___ High Blood Pressure
___ Fatigue
___ Cholesterol
___ Anxiety
___ Thyroid
___ Psychiatric
___ Blood abnormalities
___ Diabetes: (circle) Type 1 Type 2

___ Kidney
___ Stroke
___ Autoimmune
___ HIV/AIDs
___ Cancer
___ Heart
___ Tuberculosis

___ Cough
___ Prostate
___ Respiratory
___ Neurological
___ Gastrointestinal
___ Depression
___ Hepatitis

Eye Conditions:

___ Cataracts ___ Glaucoma ___ Macular Degeneration ___ Dry Eye

Any other eye/medical conditions not mentioned above: _____

_____

_____

Eye Surgery History: _____

_____

_____

THE WITLIN CENTER

FOR ADVANCED EYECARE

General Surgery History: _____

_____

_____

Family Eye History: _____

_____

_____

Family Medical History: _____

_____

_____

Cataract Surgery Pre-Op Questionnaire

Patient Name: _____ Date: _____

Do you have difficulty, **even with glasses**, with the following activities?

1. 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 ☐ A Great Deal ☐ 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 ☐ A Great Deal ☐ 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 ☐ A Great Deal ☐ 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 ☐ A Great Deal ☐ 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 ☐ A Great Deal ☐ 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 ☐ A Great Deal ☐ 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 ☐ A Great Deal ☐ 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 ☐ A Great Deal ☐ 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 ☐ A Great Deal ☐ 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 ☐ A Great Deal ☐ 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 ☐ A Great Deal ☐ 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 ☐ A Great Deal ☐ Unable to do the Activity

Patient Signature: _____ **Date: _____**

Johnson & Johnson VISION

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

 Driving

 Golf

 Sporting events

 Scenery

OTHER

INTERMEDIATE

 Car dashboard

 Computer

 Grocery shopping

 Mobile phone or tablet

OTHER

NEAR

 Fine print

 Games & puzzles

 Sewing

 Makeup

OTHER

2 **On average, how many hours per day do you spend:**

please indicate the number next to the activity;

___Driving	___Engaging in lifestyle activities (i.e. golf, gardening, cooking, etc.)	___Using media devices (i.e. mobile phone, tablet, e-reader)	___Reading books, newspapers	___Knitting, reading fine print

3 **Thinking long-term, how important is it that you rely on your glasses less often?**

☐ I don't mind ☐ It'd be nice ☐ Glasses are annoying ☐ I hate wearing them

4 **How often do you drive in low-light conditions (dusk, night, dawn, rain)?**

☐ Never ☐ Not often, but I'd like to ☐ Occasionally ☐ Often

5 **As best you can, mark where your personality type fits on this scale.**

Easygoing — Perfectionist

6 **I know that my insurance may only cover some of the procedure, and I want to learn about my treatment options.**

☐ Agree ☐ Disagree

If my procedure is not fully covered by insurance, I want to learn about financing options.

☐ Agree ☐ Disagree

7 **To ensure your visit is a great experience, please share any questions or concerns you would like us to know about.**

Johnson & Johnson VISION