THE WITLIN CENTER

FOR ADVANCED EYECARE

Last Name:	**First Name:**
Birthday:	**Social Security #:**

Home Street Address:	**Town and Zip Code:**
Cell Phone #	**Home Phone #**

Pharmacy Name:	**Pharmacy Address (Town):**
Pharmacy Phone #:	

Family Physician (PCP) Name:	**Family Physician (PCP) Phone #:**
Referring Physician Name:	**Referring Physician Phone #**

Emergency Contact Name:	**Emergency Contact Phone #**
HIPAA Approved Contact Name:	**HIPAA Contact Phone #**
HIPAA Contact Relation:	

Patient Signature:	**Signature Date:**

Date:_____

Name:_____ **Date of birth:**_____

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.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list all allergies to food/ medications/ latex:

_____ _____ _____

Check any of the following conditions that apply to you:

___High blood pressure
___Stroke
___Respiratory
___Thyroid
___Heart
___Tuberculosis
___Kidney
___Prostate
___Anxiety
___Cancer
___Depression
___Hepatitis
___Cough
___Cholesterol
___HIV/ AIDS
___Gastrointestinal
___Blood abnormalities
___Diabetes(circle): Type 1 Type 2
___Fatigue
___Autoimmune
___Neurological
___Psychiatric

Last A1C_____ Last BS_____ Fasting/ Not

Eye Conditions: ___Cataracts ___Glaucoma ___Macular Degeneration ___Dry Eye

Any other eye/ medical conditions not mentioned above:_____

_____

_____

Surgery History:_____

_____

_____

Eye Surgery History:_____

_____

_____

Family Medical History: _____

_____

_____

Family Eye 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.**

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Refraction Acknowledgment- Cataract Evaluation

Refractions are an essential part of your cataract evaluation. The doctor uses the results to identify the visual acuity potential relative to eye conditions including diabetes, cataracts, macular degeneration, etc., and to confirm your surgical candidacy.

These are vital components of the calculations that optimize the medical assessment and determination of your surgical candidacy. **Without this information, our doctors cannot proceed with cataract surgery.**

The out-of-pocket cost for refraction service is $75. Despite significant diagnostic value, most insurance carriers including Medicare deem it a non- covered service.

- ❑ I understand that Medicare deems a refraction a non-covered service and I am responsible for the $75 payment at time of service.

- ❑ I understand that my refraction fee of $75 will be submitted to my non-Medicare insurance plan and I may be charged $75 should they deem it a non-covered service.

I have read the above information and have had any questions answered to my satisfaction. I further acknowledge that this is a signed document and will remain part of my permanent record and apply to any future refraction fees I may incur under my care.

Printed Patient Name: _____

Signature: _____

Date: _____