Patient Name (Last, First): _____

Address: _____City:_____ Postal Code: _____

Phone Numbers: (H) _____ (C) _____ (W) _____

Birthdate (mm/dd/yyyy): _____ Gender: Male _____ Female _____ Other: _____

Age: _____Weight: _____ Height: _____ Average Blood Pressure: _____ Language: _____

Family Doctor (include first name): _____ Optometrist: _____

Emergency Contact: _____ Phone Number: _____

REASON FOR APPOINTMENT:

_____ Cataracts _____ Glaucoma _____ Diabetes (Blood sugar:_____)

_____ Routine Exam _____ Floaters/Flashes

_____ Other (explain): _____

DO YOU WEAR ANY OF THE FOLLOWING:

_____ Reading Glasses _____ Distance Glasses _____ Contact Lenses

_____ Progressives _____ Bifocals _____ None

DO YOU HAVE A FAMILY HISTORY OF ANY EYE DISEASES:

_____ NO _____ YES, who and what condition?: _____

List the name of ALL medications that you take (including herbal, vitamins, and non-prescription drugs):

_____

_____

_____

_____

_____

ALLERGIES:	**REACTION:** **_____ None**

Do you have or have you ever had:

____ Heart pain ____ Heart attack ____ Heart valve problem ____ Stroke

____ High Blood Pressure ____ Diabetes ____ Asthma ____ Bronchitis

____ Emphysema ____ Hepatitis ____ Kidney problems ____ Thyroid problems

____ Liver problems ____ Hiatus hernia ____ Jaundice ____ Stomach problems

____ Heart burn ____ Weakness ____ Arthritis ____ Bleeding disorder

____ Paralysis ____ Seizures ____ Malignancy

____ Numbness of face/limbs ____ Others: _____

____ Infectious disease: _____

Have you had eye laser surgery or any operations to your eyes: _____ NO _____ YES

If yes, what did you have done and when: _____

List the name and year of ALL operations:

_____

_____

_____

_____

SURVEY FOR CATARACT PATIENTS

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


Live sports


Scenery

Other:

INTERMEDIATE


Car dashboard


Computer


Grocery shopping


Tablet

Other:

NEAR


Fine print


Detailed hobbies


Mobile phone


Makeup

Other:

2. What do you currently find challenging or bothersome? Please indicate with a check below.

- O Streetlights/ headlights
- O Reading
- O TV captions
- O Bright daylight

3. When you think long term, would you like to rely on your glasses less? Please indicate with a check below:

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

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

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

5. Please describe your personality type as best you can.

- O Easygoing
- O Organized, but flexible
- O Always plans ahead
- O Perfectionist

6. Please share any questions or concerns you many have

_____

_____

_____