

**Comprehensive Cataract Examination  
Patient History Questionnaire**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First) (MI)

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

If an eye doctor suggested you see us, please provide the doctor's name: \_\_\_\_\_

What bothers you most about your current vision and how it impacts your quality of life?

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List activities and hobbies that you enjoy: \_\_\_\_\_

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Have you had any other second opinions about your vision?  Yes  No

If yes, with who? \_\_\_\_\_

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What questions do you have that we could address during your consultation?

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## Medical and Eye History

List all **eye injuries or diseases** you have had (glaucoma, cataract, etc.):

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List all **eye surgeries** you have had:

	Type of Surgery	Which Eye	Surgeon's Name	Date
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____
4)	_____	_____	_____	_____

List all **eye drops** you use, which eye, and how often you use them:

	Medication Name	Dosage	Frequency
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____

List any **oral, topical or injected** medications you currently take (This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements):

	Medication Name	Dosage	How Often	Route of Administration
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____
4)	_____	_____	_____	_____
5)	_____	_____	_____	_____
6)	_____	_____	_____	_____
7)	_____	_____	_____	_____
8)	_____	_____	_____	_____
9)	_____	_____	_____	_____
10)	_____	_____	_____	_____

List all **medical problems** you have:

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List any medications you are **allergic** to:

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If female, are you or might you be pregnant?  Yes  No

Do you **currently** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
<b>GENERAL / CONSTITUTIONAL</b> (fever, heat stroke, weight loss, weight gain, unusually tired)			
<b>EARS, NOSE, THROAT</b> (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
<b>CARDIOVASCULAR</b> (high BP, racing pulse, etc.)			
<b>RESPIRATORY</b> (congestion, wheezing, short of breath, etc.)			
<b>GASTROINTESTINAL</b> (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
<b>GENITAL, KIDNEY, BLADDER</b> (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
<b>FEMALES</b> Are you pregnant? Nursing?			
<b>MUSCLES, BONES, JOINTS</b> (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
<b>SKIN</b> (growths, rashes, etc.)			
<b>NEUROLOGICAL</b> (numbness, headache, seizures, paralysis, etc.)			
<b>PSYCHIATRIC</b> (anxiety, depression, insomnia)			
<b>ENDOCRINE</b> (diabetes, hypothyroid, etc.)			
<b>BLOOD / LYMPH</b> (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
<b>ALLERGIC / IMMUNOLOGIC</b> (sneezing, swelling, redness, itching, hives, lupus, etc.)			

**FAMILY HISTORY**

**(Mother, Father, Grandparent, Sibling)**

Has any member of your family had these diseases (circle all that apply)?

**Blindness, Keratoconus, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis**

Other heritable disease:

**SOCIAL HISTORY**

Do you drink alcohol? .....YES NO If YES, how much? \_\_\_\_\_

Do you smoke? .....YES NO If YES, how much? \_\_\_\_\_ How many years? \_\_\_\_\_

Received tobacco cessation counseling

I attest that I have reviewed the questionnaire.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Pre-Operative Cataract Surgery - Visual Functioning Index (VF-8R) Patient Questionnaire

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

<b>1. Reading small print such as labels on medicine bottles, a telephone book or food labels?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If <b>yes</b> , how much difficulty do you currently have?	<input type="checkbox"/> A Little <input type="checkbox"/> A Moderate Amount <input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity	
<b>2. Reading a newspaper or book?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If <b>yes</b> , how much difficulty do you currently have?	<input type="checkbox"/> A Little <input type="checkbox"/> A Moderate Amount <input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity	
<b>3. Seeing steps, stairs or curbs?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If <b>yes</b> , how much difficulty do you currently have?	<input type="checkbox"/> A Little <input type="checkbox"/> A Moderate Amount <input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity	
<b>4. Reading traffic, street or store signs?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If <b>yes</b> , how much difficulty do you currently have?	<input type="checkbox"/> A Little <input type="checkbox"/> A Moderate Amount <input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity	
<b>5. Doing fine handwork like sewing, knitting, crocheting or carpentry?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If <b>yes</b> , how much difficulty do you currently have?	<input type="checkbox"/> A Little <input type="checkbox"/> A Moderate Amount <input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity	
<b>6. Writing checks or filling out forms?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If <b>yes</b> , how much difficulty do you currently have?	<input type="checkbox"/> A Little <input type="checkbox"/> A Moderate Amount <input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity	
<b>7. Playing games such as bingo, dominos, card games or mahjong?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If <b>yes</b> , how much difficulty do you currently have?	<input type="checkbox"/> A Little <input type="checkbox"/> A Moderate Amount <input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity	
<b>8. Watching television?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
If <b>yes</b> , how much difficulty do you currently have?	<input type="checkbox"/> A Little <input type="checkbox"/> A Moderate Amount <input type="checkbox"/> A Great Deal <input type="checkbox"/> Unable to do the activity	

