Patient Name:_____ Practice: Virginia Eye Center, PC

Date:_____

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

Do you have difficulty, even with glasses, with the following activities? Please answer for each eye.

	Right Eye	Left Eye
1. Reading small print such as labels on medicine bottles, a telephone book or food labels?	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A moderate amount	☐ A little ☐ A moderate amount
	☐ A Great Deal ☐ Unable to do the activity	☐ A Great Deal ☐ Unable to do the activity
2. Reading a newspaper or book?	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A moderate amount	☐ A little ☐ A moderate amount
	☐ A Great Deal ☐ Unable to do the activity	☐ A Great Deal ☐ Unable to do the activity
3. Seeing steps, stairs or curbs?	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A moderate amount	☐ A little ☐ A moderate amount
	☐ A Great Deal ☐ Unable to do the activity	☐ A Great Deal ☐ Unable to do the activity
4. Reading traffic signs, street signs or store signs?	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A moderate amount	☐ A little ☐ A moderate amount
	☐ A Great Deal ☐ Unable to do the activity	☐ A Great Deal ☐ Unable to do the activity
5. Doing fine handwork like sewing, knitting, crocheting or carpentry?	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A moderate amount	☐ A little ☐ A moderate amount
	☐ A Great Deal ☐ Unable to do the activity	☐ A Great Deal ☐ Unable to do the activity
6. Writing checks or filling out forms?	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A moderate amount	☐ A little ☐ A moderate amount
	☐ A Great Deal ☐ Unable to do the activity	☐ A Great Deal ☐ Unable to do the activity

	Right Eye	Left Eye
7. Playing games such as bingo, dominos, card games or mahjong?	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A moderate amount	☐ A little ☐ A moderate amount
	☐ A Great Deal ☐ Unable to do the activity	☐ A Great Deal ☐ Unable to do the activity
8. Watching television?	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A little ☐ A moderate amount	☐ A little ☐ A moderate amount
	☐ A Great Deal ☐ Unable to do the activity	☐ A Great Deal ☐ Unable to do the activity

Have you been bothered by:	**Right Eye**	**Left Eye**
Poor night vision or trouble driving?	☐ Yes ☐ No	☐ Yes ☐ No
Glare caused by headlights or bright sunlight?	☐ Yes ☐ No	☐ Yes ☐ No
Seeing rings or halos around lights?	☐ Yes ☐ No	☐ Yes ☐ No

Personal Interests

Please list your favorite hobbies? _____

_____

Circle the number on the following scale to describe your personality.

1 2 3 4 5 6 7 8 9 10

Easygoing **Perfectionist**

_____ _____

Patient Signature Date

Patient Name: _____

Date: _____

OFFICE USE ONLY:
LASIK/PRK/PRK/RK/CK _____
CONTACTS _____
RGP _____
SOFT CL _____

Have you worn contact lenses in the past 6 months?

YES_____ **NO**_____

If **yes**, are they soft contacts or RGP lenses?

Soft_____ **RGP**_____

When was the last time you wore your contacts? _____

Have you had any corneal surgery? **YES** _____ **NO** _____

If **yes**, what type of surgery? **(Circle One)** PRK / Lasik / RK / Other _____

If **yes**, when and where did you have the surgery?

_____

_____

Please read the following and sign below

If you wear soft contact lenses, you will need to stop wearing your lenses prior to your measurement appointment.

- **5 days for standard soft contact lenses**
- **14 days for astigmatism correcting soft contact lenses.**

If you wear RGP lenses, you will need to **stop wearing your lenses for several months prior to your surgery**. You will also come into the office several times during this period for measurements of your cornea.

I understand that failure to comply with these instructions will compromise the success of my visual outcome from cataract surgery.

Patient Signature: _____

Date: _____

CONSENT-WAIVER FOR CORNEAL TOPOGRAPHY TESTING

Your doctor utilizes the most current, up-to-date technology for gathering information which assists in providing you with the very best medical care for your vision. The corneal topography test will provide valuable information to more accurately calculate the correction and amount of correction you may require for your upcoming cataract surgery, including determining if you are a viable candidate for an astigmatism correcting or multifocal advanced technology lens. Because not all insurance companies cover the cost of this test and consider it a non-covered service, if performed, you may be financially responsible. We do not expect that your insurance company will cover the cost of this test.

Test Fees:

The cost for the corneal topography test (CPT 92025) is $85.00.

Beneficiary Agreement

In signing, I understand that my physician has recommended a non-covered, optional service. The fees associated with the corneal topography test have been explained and I understand that I am hereby agreeing in advance, in writing, to accept full financial responsibility for all costs associated with this non-covered medical service which is $85.00.

_____

Patient Signature (or person authorized to sign for patient)

_____ _____

Printed Name Date