Patient Name:_____ **Date:**_____

Pre-Cataract Surgery Patient Questionnaire

Do you have difficulty, even with glasses on, with the following activities?
Please mark an "X" on the scale (line) where you would rate your difficulty, or circle "None" or "Unable to Do Activity" if applicable.

Reading small print such as labels on medicine bottles, newspaper, food labels, writing checks, or filling out forms?

Right Eye: none , or _____ , or Unable to Do Activity
A little Moderate Amount A Great Deal

Left Eye: none , or _____ , or Unable to Do Activity
A little Moderate Amount A Great Deal

Playing games such as bingo, dominos, card games or Mahjong?

Right Eye: none , or _____ , or Unable to Do Activity
A little Moderate Amount A Great Deal

Left Eye: none , or _____ , or Unable to Do Activity
A little Moderate Amount A Great Deal

Doing fine handwork like sewing, knitting, crocheting or carpentry?

Right Eye: none , or _____ , or Unable to Do Activity
A little Moderate Amount A Great Deal

Left Eye: none , or _____ , or Unable to Do Activity
A little Moderate Amount A Great Deal

Seeing steps, stairs or curbs?

Right Eye: none , or _____ , or Unable to Do Activity
A little Moderate Amount A Great Deal

Left Eye: none , or _____ , or Unable to Do Activity
A little Moderate Amount A Great Deal

Reading traffic signs, street signs or store signs?

Right Eye: none , or _____ , or Unable to Do Activity
A little Moderate Amount A Great Deal

Left Eye: none , or _____ , or Unable to Do Activity
A little Moderate Amount A Great Deal

Watching television?

Right Eye: none , or _____ , or Unable to Do Activity
A little Moderate Amount A Great Deal

Left Eye: none , or _____ , or Unable to Do Activity
A little Moderate Amount A Great Deal

Patient Name:_____ **Date:**_____

Have you been bothered by:

Poor night vision or trouble driving? ☐ Yes ☐ No

Glare caused by headlights or bright sunlight? ☐ Yes ☐ No

Seeing rings or halos around lights? ☐ Yes ☐ No

After Surgery, would you be most interested in seeing well without glasses in this situation?

- **Distance Vision** (driving, watching television, sports activities)
  _____Prefer no distance glasses _____I don't mind wearing distance glasses

- **Mid-Range Vision** (computer, cooking, makeup application, board games, vehicle dashboard)
  _____Prefer no Mid-Range glasses _____I don't mind wearing Mid-Range glasses

- **Near Vision** (reading, detailed handwork hobbies)
  _____Prefer no near glasses _____I don't mind wearing near glasses

Cataract Surgery is usually covered by insurance, but advanced technologies are available to increase the possibility that glasses might not be needed after surgery. These enhanced options are not covered by insurance and would be an out-of-pocket expense. Would these options be something you are interested in?

____ Yes ____No ____Maybe, depending on the cost

Please mark on the scale describing your personality

1	2	3	4	5	6	7	8	9	10
Easy Going									Perfectionist

Is there anything else that we should know (other visual complaints, concerns, hobbies)?

_____

_____

_____

Patient (or Representative) Signature

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, 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 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

6/9/2022

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: _____