MARIETTA EYE CLINIC CELEBRATING 50 YEARS

Dear Patient,

Thank you for choosing Marietta Eye Clinic for your cataract surgery consultation! Helping patients restore sight with this amazing procedure is a primary focus of our practice and has been performed over 50,000 times during our 50-year history.

Cataract surgery has evolved considerably over the last 20 years and is considered to be one of the safest and most successful surgical procedures performed in the United States today. At Marietta Eye Clinic, we offer customized options including today's most advanced lens selection and precision laser technology.

Once you've made the decision to have cataract surgery, there are important choices and custom vision opportunities ahead based on your personal preferences and interests. Recent innovations have created a variety of lens designs, each with their own unique features. Your lens selection is an important decision since you will be looking through these lenses for the rest of your life. We want you to choose the implant that will help you regain your lifestyle and what you love to do most.
Please feel free to discuss your lens options with family or friends.

We now also offer an advanced laser treatment that can effectively treat both your cataracts and astigmatism within the same procedure. In addition to removing your cataract with precision, the laser will reshape your cornea to reduce your astigmatism with the ultimate goal of further enhancing your vision and decreasing your dependency on glasses.

Before your office visit, we kindly ask that you read the enclosed materials. Please also complete the "Patient Medical Information," "Vision Preferences Checklist" and bring them (along with Insurance card and Picture ID) to your appointment. You can expect to be in the office for at least three hours for your cataract consultation, as we will do a complete examination including dilation of your eyes and multiple pre-surgical measurements. It is always advisable to have a driver after your eyes have dilated.

Cataract surgery is a one-in-a-lifetime procedure with an opportunity to permanently change how you see the world. We look forward to helping you see your best!

Abigail Kalish, M.D.

895 Canton Road, Marietta GA 30060 ● (770) 427-8111 ● Fax (770) 427-6913 ● www.MariettaEye.com

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PATIENT MEDICAL INFORMATION

MARIETTA EYE CLINIC

The following information is needed by your Physician to provide the best type of care for you.

Patient Name _____ Birth Date _____ Age _____

Primary Parent/Guardian Name _____

Cell Phone Number (_____)_____-_____ Home Number (_____)_____-_____

Email Address _____

Emergency Contact Person with different phone number

Name _____ **Phone** (_____)_____-_____

Does the Patient live in a **Nursing Facility**? If so, which Facility?

Name _____ **Phone** (_____)_____-_____

Primary Physician Name _____ **Phone** (_____)_____-_____

Last Seen _____

Cardiologist Name _____ **Phone** (_____)_____-_____

Last Seen _____

Pulmonologist Name _____ **Phone** (_____)_____-_____

Last Seen _____

Neurologist Name _____ **Phone** (_____)_____-_____

Last Seen _____

Pharmacy Name _____ **Phone** (_____)_____-_____

Address _____

Patient Height _____ **Weight** _____ Any body piercings? (Location) _____

Allergies / Sensitivities	Reactions
_____	_____
_____	_____
_____	_____
_____	_____

Latex Allergy? Yes ☐ No ☐

Reaction _____

Ocular History: Have you ever been treated for the following?:

Y ☐ N ☐ Retinal Tear or Detachment

Y ☐ N ☐ Cataract

Y ☐ N ☐ Cornea Problem

Y ☐ N ☐ Eye Muscle Problems

Y ☐ N ☐ Glaucoma

Y ☐ N ☐ Diabetic Eye Disease

Y ☐ N ☐ Eye Trauma or Injury

Any other eye surgeries? _____

_____

_____

PATIENT MEDICAL INFORMATION

MARIETTA EYE CLINIC

Patient Name _____ **DOB** _____

CURRENT MEDICATIONS including vitamins, herbal supplements, over-the-counter medications, etc.

Please add dosage and frequency.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

SOCIAL HISTORY

Are you taking any diet/appetite suppressants medications? Yes ☐ No ☐ Last date taken _____

Smoke? Yes ☐ No ☐ _____ packs per day for _____ years I quit _____ years ago

Drink? Yes ☐ No ☐ How much? _____

Illegal or Prescription Drug Abuse? Yes ☐ No ☐ Which drug? _____

MEDICAL HISTORY Do you have or have you had: (If you mark "yes," please explain)

PATIENT

CARDIAC DISEASE

☐ YES ☐ NO **Implantable cardioverter-defibrillator (AICD)?**

☐ YES ☐ NO **STENTS? DATE:** _____

"Yes" to following require cardiology notes:

☐ YES ☐ NO **A-FIB/PALPITATIONS?**

☐ YES ☐ NO **Pacemaker? Date:** _____ **Cardiac Bypass? (CABG) Date:** _____

☐ YES ☐ NO **Chest pains/angina/congestive heart failure/swelling to lower extremities?**

(Circle all that apply)

☐ YES ☐ NO Can you walk up 2 flights of steps without feeling short of breath?

☐ YES ☐ NO Can you lie down flat for 30 minutes without feeling short of breath?

☐ YES ☐ NO High blood pressure?

☐ YES ☐ NO Are you taking aspirin or blood thinners?

PULMONARY DISEASE

☐ YES ☐ NO **HOME OXYGEN?**

☐ YES ☐ NO **COPD?**

☐ YES ☐ NO Asthma/Wheezing? **(Circle all that apply)**

Date of last attack: _____

☐ YES ☐ NO Chronic Cough?

☐ YES ☐ NO Sleep Apnea? YES ☐ NO ☐ Do you use CPAP?

PATIENT MEDICAL INFORMATION

MARIETTA EYE CLINIC

Patient Name _____ **DOB** _____

MEDICAL HISTORY Do you have or have you had: (If you mark "yes," please explain) cont.

PATIENT

NEUROLOGICAL

☐ YES ☐ NO **STROKE? Date:** _____

☐ YES ☐ NO **TIA? Date:** _____

☐ YES ☐ NO Seizures/eplipesy? **(Circle all that apply)** Date of last seizure: _____

☐ YES ☐ NO Tremors/Parkinson's Disease? **(Circle all that apply)**

ENDOCRINE

☐ YES ☐ NO Do you have diabetes?

☐ YES ☐ NO Do you require insulin?

What was your last A1C level? _____

☐ YES ☐ NO Thyroid Disease?

KIDNEY DISEASE

☐ YES ☐ NO Kidney Disease? Stage _____

☐ YES ☐ NO Dialysis? What days? _____

LIVER DISEASE

☐ YES ☐ NO Liver Disease/Cirrhosis? **(Circle all that apply)**

☐ YES ☐ NO Anemia/Blood Transfusion? **(Circle all that apply)** When? _____

☐ YES ☐ NO Sickle Cell Disease or Trait?

☐ YES ☐ NO Do you have a history of blood clots or a bleeding disorder?

*Be advised if you have an uncontrolled high blood pressure the day of surgery, the anesthesiologist may cancel your surgery.

**Be advised if your blood sugar is above 275 the day of surgery, your surgery will be cancelled.

ANESTHESIA

☐ YES ☐ NO Problems with anesthesia?

☐ YES ☐ NO TMJ?

☐ YES ☐ NO Difficult IV start?

☐ YES ☐ NO Slow to wake up from anesthesia?

☐ YES ☐ NO Ulcer/Hiatal Hernia/Reflux or Heartburn? (Circle all that apply)

☐ YES ☐ NO Any broken facial bones (nose or jaw)?

☐ YES ☐ NO Dentures/bridges/loose teeth caps/crowns? (Circle all that apply)

☐ YES ☐ NO Could you be pregnant?

☐ YES ☐ NO List previous surgeries: _____

_____

_____

PATIENT MEDICAL INFORMATION

MARIETTA EYE CLINIC

Patient Name _____ **DOB** _____

INFECTIOUS DISEASE

☐ YES ☐ NO Ever been diagnosed with HIV, AIDS, HEPATITIS, TB, C-DIFF/MRSA? (active MRSA not ASC candidate)

☐ YES ☐ NO Have you completed your COVID vaccination(s)? Date of last injection _____

OTHER

☐ YES ☐ NO Do you have any surgical implants or prosthesis?

☐ YES ☐ NO Arthritis? Chronic back pain?

☐ YES ☐ NO Do you have other health concerns?

☐ YES ☐ NO **Sick or hospitalized in the last 30 days? (need hospital notes)**

☐ YES ☐ NO Do you feel unsteady when standing or walking?

☐ YES ☐ NO Do you use assistive devices to walk?

☐ YES ☐ NO Are you able to transfer from wheelchair to stretcher with minimal assistance?

PEDIATRIC PATIENTS (additional questions)

☐ YES ☐ NO Born Full term?

☐ YES ☐ NO Did your child spend any time in the ICU when born?

☐ YES ☐ NO Meeting all developmental milestones for age?

☐ YES ☐ NO Has your child ever been evaluated by a cardiologist, a pulmonologist, or a neurologist for any reason?

Signature of Patient: X _____ Date: _____

Signature of Primary Parent/Guardian: X _____ Date: _____

- -

PATIENTS: DO NOT FILL OUT INFORMATION BELOW. THIS IS FOR PHYSICIANS USE ONLY

Other Findings: _____

_____

Date updated with patient _____ Tech/Nurse sig _____

Date updated with patient _____ Tech/Nurse sig _____

Date updated with patient _____ Tech/Nurse sig _____

HISTORY REVIEW

Reviewed By: _____,RN/LPN Date_____Time:_____am/pm

Reviewed By: _____, MD - Surgeon/Anesthesiologist Date_____Time:_____am/pm

Reviewed By: _____,RN/LPN Date_____Time:_____am/pm

Reviewed By: _____, MD - Surgeon/Anesthesiologist Date_____Time:_____am/pm

MARIETTA
EYE CLINIC
DOCTORS • SURGEONS • EYEWEAR

Vision Preferences Checklist (PLEASE BRING WITH YOU TO CONSULTATION)

Cataract surgery is a once-in-a-lifetime procedure with an opportunity to permanently change how you see the world. With advances in today's lens technology, combined with precision laser surgery enhancements, vision after cataract surgery can be improved like never before! Your Marietta Eye Clinic team will help educate you about the variety of choices available. This questionnaire can provide insight on how you expect to see after your procedure. **It is important to understand that most patients will need glasses for some activities after cataract surgery.**

1. **Have you worn contact lenses?** □ Yes □ No **Monovision contact lenses?** □ Yes □ No

2. **Are you interested in seeing well in the distance without glasses?** □ Yes □ No

3. **Are you interested in seeing well near (within arms-length) without glasses?** □ Yes □ No

4. **Which near vision, hand/eye activities do you enjoy or perform often?** *(check all that apply)*
   □ Carpentry □ Painting □ Cooking □ Piano / Reading Music □ Driving □ Cards □ Gardening
   □ Puzzles / Crosswords □ Needlework □ Reading Print □ Reading Mobile Phone / Tablet

5. **Which activities do you enjoy / perform most often?** *(check all that apply)*
   □ Biking □ Fishing □ Bowling □ Hunting □ Shopping □ Golfing □ Swimming
   □ Driving (Night / Day) □ Tennis □ Time with kids □ Traveling □ Watching TV □ Writing
   □ Computer (# of hours daily)_____ □ Others_____

6. **How enjoyable would it be for you to be free of glasses for all of your daily activities?**
   □ Awesome □ Very Nice □ OK □ Not a Big Deal

7. **Do you do a lot of night driving?** □ Yes □ No □ Somewhat

8. **How would you describe your personality?** *(Place an "X" on the following scale)*

Easy Going----------|----------Perfectionist

Patient Name: _____DOB:_____ Date: _____

Patient Questionnaire Patient Name_____

Please Check Eye(s) with Symptoms:

Left ☐ Right ☐

VISUAL FUNCTIONING

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

YES	NO	
		Reading small print, such as labels on medicine bottles, food labels or text on a smartphone?
		Reading a newspaper, book or tablet?
		Reading a large-print book, large print newspaper or large numbers on a telephone?
		Recognizing people when they are close to you?
		Seeing steps, stairs or curbs?
		Reading traffic signs, street signs or store signs?
		Doing fine handwork like sewing, knitting, crocheting, or carpentry?
		Writing checks or filling out forms?
		Playing games such as bingo, dominos, or card games?
		Taking part in sports like bowling, handball, tennis, or golf?
		Cooking?
		Watching television or looking at a computer/laptop screen?

SYMPTOMS

Have you been bothered by:

YES	NO	
		Poor night vision?
		Seeing rings or halos around lights?
		Glare caused by headlights or bright sunlight?
		Hazy and/or blurry vision?
		Night Driving?
		Day Driving?
		Seeing well in poor or dim light?
		Poor color vision?
		Double Vision?

Patient Signature

_____

Date

_____