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!

Board Certified Ophthalmologist
Allison Dublin

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

PATIENT MEDICAL INFORMATION

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 ____

Daytime phone number (______) ______ - ______ Alternate number (______) ______ - ______

Emergency contact person with different phone number **Name** ______________________

Phone (______) ______ - ______

Does the patient live in a **nursing facility**? If so, which facility?

Facility name ______________________ **Facility phone** (______) ______ - ______

Referring doctor for this visit ____

Do you need a letter sent to your referring doctor? Yes No (Circle One)

Primary physician name ______________ Phone ______________ Last seen ______________

Cardiologist name ______________ Phone ______________ Last seen ______________

Pulmonologist / neurologist ______________________ Phone ______________________

Pharmacy name ______________________ Phone ______________________

Patient height __________ **Weight** __________ Any body piercings? (Location) ______________

Allergies / Sensitivities Reactions

______________ ______________________ **Latex allergy?** Yes / No

______________ ______________________ Reaction ______________

______________ ______________________

Current medications, including vitamins, herbal supplements, and over-the-counter medications

Please include dosage and frequency.

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

Are you taking aspirin or blood thinners? Yes / No Last date taken ______________

Are you taking any diet/appetite suppressant medications? Yes / No Last date taken ______________

SOCIAL HISTORY

Smoke No / Yes How much? ______________________ I quit ____ years ago.

Drink No / Yes How much? ______________________________

Illegal or prescription drug abuse No / Yes Which drug? ______________________

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 or pulmonologist for any reason?

____

PATIENT MEDICAL INFORMATION

Patient Name ______________________________

PATIENT MEDICAL HISTORY Do you have or have you had: (If you circle "Yes," please explain)

Yes No **Problems with anesthesia?** ______________________________
Yes No TMJ/difficult IV stick/slow to awaken from anesthesia?
Yes No Is it difficult for you to walk up 2 flights of steps without feeling short of breath?
Yes No Is it difficult for you to lie down flat for 30 minutes without feeling short of breath?
Yes No **Cardiac disease? heart attack/heart murmur/heart valve/CABG/stent/pacemaker A-fib/palpitations** ______________________________
Pacemaker: Date ____________ **CABG: Date** ____________
Yes No **Cardiac Stents: Date** ____________ **Valve Replacement: Date** ____________
Yes No **Chest pains/angina/congestive heart failure/swelling to lower extremities?**
____
Yes No High blood pressure?* ____________ Controlled on medication? ____________
Yes No Diabetes?** ____________ Average a.m. fasting blood sugar: ____________
Yes No **Lung disease/COPD?** shortness of breath or chronic cough? ____________
Yes No Do you use **oxygen**? How often? ____________
Yes No Asthma/wheezing? Date of last attack: ____________
Yes No **Sleep apnea?** ____________ Do you use CPAP? ____________
Yes No Do you have any broken facial bones (nose or jaw)? ____________
Yes No Do you have dentures/bridges/loose teeth/caps/crowns? ____________
Yes No Do you have problems hearing? Wear a hearing aid? ____________
Yes No Do you have any surgical implants or prosthesis? ____________
Yes No Thyroid disease? ____________
Yes No Ulcer/hiatal hernia/reflux or heartburn? ____________
Yes No Liver disease/jaundice/cirrhosis/other? ____________
Yes No Infectious disease: hepatitis/HIV/TB/C-diff/MRSA ____________
Yes No **Stroke/TIA/paralysis?** ____________ Date: ____________
Yes No Seizures/epilepsy? Date of last seizure: ____________
Yes No Tremors/Parkinson's disease? ____________
Yes No Arthritis/joint pain/chronic back pain? ____________
Yes No Bladder/prostate problems? ____________
Yes No **Kidney disease/dialysis?** ____________ What days? ____________
Yes No Anemia/blood transfusion? When? ____________
Yes No Sickle cell disease or trait? ____________
Yes No Are you or could you be pregnant? ____________
Yes No Have you had previous surgery, including eye surgery (please list)?
____
Yes No Do you have other health concerns? ____________
Yes No **Have you been sick or in the hospital in the last 30 days?** ____________
Yes No Have you fallen in the past year? ____________
Yes No Do you feel unsteady when standing or walking? ____________
Yes No Do you use any assistive devices to walk? ____________
Yes No Are you able to transfer from wheelchair to stretcher with minimal assistance?

* 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.

PATIENT MEDICAL INFORMATION

Patient Name ______________________________

Ocular History: Have you ever been diagnosed with any of the following?

Y N Retinal Tear or Detachment Y N Cataract Y N Cornea Problem
Y N Glaucoma Y N Diabetic Eye Disease Y N Eye Trauma or Injury
Y N Eye Muscle Problems

Any other eye problems:

Do you wear: Glasses Contact Lenses

FAMILY HISTORY
Has anyone in your immediate family been diagnosed with the following?
(If yes, please indicate relationship.)

Yes No Diabetes? ______________________
Yes No High Blood Pressure? ______________________
Yes No Heart Disease? ______________________
Yes No Stroke? ______________________
Yes No Cancer? Type: ______________________
Yes No Glaucoma? ______________________
Yes No Macular Degeneration? ______________________
Yes No Retinal Detachment? ______________________
Yes No Blindness? ______________________

Please circle "Y" if you have had any of these conditions in the last few weeks.

Constitutional	**Cardiovascular**	**Metabolic/Endocrine**	**Integumentary**
Y N Fatigue	Y N Arrhythmia	Y N Cold Intolerance	Y N Abnormal Hair
Y N Fever	Y N Calf Pain	Y N Heat Intolerance	Y N Dry Skin
Y N Night Sweats	Y N Irregular Heartbeat	Y N Increased Thirst	Y N Hives
Y N Weakness	Y N Palpitations	Y N Increased Hunger	Y N Itching Skin
Y N Weight Loss	Y N Chest pain	Y N Increased Urination	Y N Nail Changes
Y N Weight Gain	Y N Fluid Retention	Y N Low Blood Sugar	Y N Rash
	Y N Leg Swelling		Y N Skin Lesion
HEENT	**Gastrointestinal**	**Neurological**	**Musculoskeletal**
Y N Exophthalmos	Y N Decreased Appetite	Y N Balance Disturbance	Y N Back Pain
Y N Hoarseness	Y N Abdominal Pain	Y N Dizziness	Y N Fracture
Y N Hearing Loss	Y N Constipation	Y N Focal Weakness	Y N Painful Joints
Y N Sinus Problems	Y N Diarrhea	Y N Headache	Y N Gait Disturbance
Y N Sore Throat	Y N Heartburn	Y N Memory Difficulty	Y N Joint Swelling
Y N Ringing in Ears	Y N Nausea	Y N Numbness/Tingling	Y N Muscle Weakness
Y N Vertigo			Y N Muscle Cramping
Respiratory	**Genitourinary**	**Psychiatric**	**Hematologic/Immunologic**
Y N Asthma	Y N Painful Urination	Y N Depression	Y N Bleeding
Y N Cough	Y N Frequent Urination	Y N Emotional Changes	Y N Bruising
Y N Coughing Blood	Y N Urgency	Y N Frequent Nightmares	Y N Tender Lymph Node
Y N Difficulty Breathing	Y N Trouble Urinating	Y N Hallucinations	Y N Environmental Allergies
Y N Diff Breath/exertion		Y N Nervousness	Y N Food Allergies
Y N Wheezing		Y N Anxiety	Y N Seasonal Allergies
		Y N Insomnia	

Signature of Patient: ______________________________ **Date:** ______________

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: _____________

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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

____

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