CLEARVIEW
• EYE CONSULTANTS •

Dear Patient,

Welcome to ClearView Eye Consultants! Thank you for placing your trust in our team.

The focus of our practice is surgery and I am dedicated to being the best surgeon I can be. I am continually refining my techniques to provide the latest technology and most effective care to my patients.

My total commitment to providing you with the best surgical care requires a team approach. Our administrative, technical, optometric and ophthalmic clinical teams are specifically trained to support me before, during and after your surgery. As a result, some or all of your care following surgery will be provided by the members of our clinical team and your referring doctor. In addition, I am always available if there are any specific questions or concerns.

I hope you will take a few minutes to review the enclosed information prior to your visit. We will review this information together on the day of your appointment. We want you to be fully informed before any decisions are made regarding your cataract surgery.

I look forward to seeing you soon.

Parag Parekh, MD

WHAT IS A LENS?

The lens is a naturally occurring structure in the eye that helps to focus light. If the lens power is mismatched to the size of the eye, patients need glasses or contact lenses to make up the difference.

Of note, this lens becomes progressively cloudy and hazy with aging and is removed during cataract surgery and replaced with a lens implant. Neither diet, medications, new glasses nor eye exercises will make the cataract go away

In Lens Replacement Surgery, the natural lens is replaced with a lens implant that is better matched to the size of the eye, reducing the need for glasses or contact lenses.

QUESTIONS ABOUT YOUR ACTIVITIES & VISION PREFERENCES:

Your answers to these questions will help you focus on which aspects of your vision are most important to you. This helps guide your surgeon in recommending the best lens to fit your needs:

1. How important is it for you to be able to see clearly without glasses after surgery?

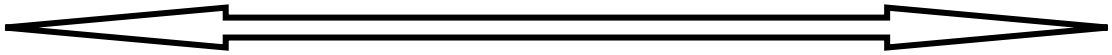
_____Very important – "I prefer not to wear glasses after surgery"
_____Moderately – "I'm not sure"
_____Not at all – "I don't mind wearing glasses after surgery"

2. If you work, what are some of your daily tasks at work? _____
3. Do you need to do a lot of night driving? Yes No
4. Do you use a computer on a daily basis? Yes No
5. What are your favorite hobbies? _____
6. Have you ever tried monovision contact lenses? Yes No
7. How would you describe your personality?

Very easy going <----------> **In Between** <----------> **Very detail oriented/perfectionist**

8. Which zone of vision is the **MOST IMPORTANT** group to you? Pick only one.

NEAR Vision **DISTANCE Vision**



ZONE 1 (12-20 in)	**ZONE 2** (2-4 ft.)	**ZONE 3** (20-100 ft.)
Newsprint	Cooking	TV
Phone book	Computer	Driving
Maps	Price Tags	Golf
Sewing	Cleaning	Road signs

WHAT ARE THE OPTIONS OFFERED?

Dr Parekh offers the full range of options to you. **Our goal is to customize your experience to your individual lifestyle needs.**

During your visit, we will take very precise measurements of your eye. This is why we ask contact lens wearers to not wear their contact lenses for at least several days prior the evaluation--this helps with the accuracy of the measurements. Based on these measurements, Dr Parekh will explain which options might fit your needs.

1. Distance Vision -- This is the option for patients who wish to have good distance vision (Zone 3), without the use of glasses, but who don't mind wearing "reading glasses" or "cheaters" for near (Zone 1) or intermediate (Zone 2) vision.

2. Near Vision -- This is the option for patients who wish to have good near vision (Zone 1), without the use of glasses, but who don't mind wearing glasses for distance (Zone 3) vision.

3. Distance & Near Vision using Monovision -- This is the option for patients who desire both distance and near vision (Zones 1-3). It involves having distance vision in the dominant eye, and reading vision in the other eye. It is important to try monovision first; we can assist you with this.

4. Distance & Near Vision using a Multifocal Lens Implant -- This is the option for patients who desire both distance and near vision (Zones 1-3), but who do not tolerate monovision.

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Visual Function Questionnaire

Dr. Parekh wants to get a good sense of the visual difficulties you are having. Please take a moment to fill out this questionnaire and bring it with you to the appointment.

1. Do you have any difficulty, even with glasses, **reading small print** such as newspapers, labels on medicine bottles, a telephone book or food labels?

☐ Yes ☐ No ☐ Not applicable

If YES, how much difficulty do you currently have?

☐ A little ☐ A moderate amount ☐ A great deal ☐ I'm unable to do the activity

2. Do you have any difficulty, even with glasses, **reading larger print**, like numbers on a telephone?

☐ Yes ☐ No ☐ Not applicable

If YES, how much difficulty do you currently have?

☐ A little ☐ A moderate amount ☐ A great deal ☐ I'm unable to do the activity

3. Do you have any difficulty, even with glasses, **seeing steps, stairs or curbs in dim light**?

☐ Yes ☐ No ☐ Not applicable

If YES, how much difficulty do you currently have?

☐ A little ☐ A moderate amount ☐ A great deal ☐ I'm unable to do the activity

4. Do you have any difficulty, even with glasses, reading **traffic signs, street signs or store signs**?

☐ Yes ☐ No ☐ Not applicable

If YES, how much difficulty do you currently have?

☐ A little ☐ A moderate amount ☐ A great deal ☐ I'm unable to do the activity

5. Do you have any difficulty, even with glasses, doing **fine handwork like sewing, knitting, using hand tools or carpentry**?

☐ Yes ☐ No ☐ Not applicable

If YES, how much difficulty do you currently have?

☐ A little ☐ A moderate amount ☐ A great deal ☐ I'm unable to do the activity

6. Do you have any difficulty, even with glasses, **writing checks or filling out forms**?

☐ Yes ☐ No ☐ Not applicable

If YES, how much difficulty do you currently have?

☐ A little ☐ A moderate amount ☐ A great deal ☐ I'm unable to do the activity

7. Do you have any difficulty, even with glasses, **playing games such as bingo, dominos, or card games**?

☐ Yes ☐ No ☐ Not applicable

If YES, how much difficulty do you currently have?

☐ A little ☐ A moderate amount ☐ A great deal ☐ I'm unable to do the activity

8. Do you have any difficulty, even with glasses, **watching television**?

☐ Yes ☐ No ☐ Not applicable

If YES, how much difficulty do you currently have?

☐ A little ☐ A moderate amount ☐ A great deal ☐ I'm unable to do the activity

9. Do you have any difficulty, even with glasses, **cooking**?

☐ Yes ☐ No ☐ Not applicable

If YES, how much difficulty do you currently have?

☐ A little ☐ A moderate amount ☐ A great deal ☐ I'm unable to do the activity

10. Do you have any difficulty, even with glasses, **driving the day**?

☐ Yes ☐ No ☐ Not applicable

If YES, how much difficulty do you currently have?

☐ A little ☐ A moderate amount ☐ A great deal ☐ I'm unable to do the activity

11. Do you have any difficulty, even with glasses, **driving at night**?

☐ Yes ☐ No ☐ Not applicable

If YES, how much difficulty do you currently have?

☐ A little ☐ A moderate amount ☐ A great deal ☐ I'm unable to do the activity

Name: _____

PAST MEDICAL HISTORY: (please circle all that apply)

Anxiety	Kidney Disease	Leukemia
Arthritis	Epilepsy/Seizures	Lymphoma
Asthma	GERD-Reflux/Heartburn	Lung Cancer
Atrial fibrillation	High Blood Pressure	Breast Cancer
BPH—Prostate Enlargemt	Hearing Loss	Colon Cancer
CVA—Stroke	HIV/AIDS	Prostate Cancer
COPD/Emphysema	High Cholesterol	Radiation Treatment
Heart Disease	Hyperthyroidism	Bone Marrow Transplant
Depression	Hypothyroidism	
Diabetes	Hepatitis	**NONE**

OTHER: _____

PAST SURGICAL HISTORY: (please circle all that apply) **L = Left R = Right**

Prostate Biopsy	Hysterectomy-Uterus Surg.			Hip Replacement	L	R
Heart Artery Bypass	Kidney Biopsy			Knee Replacement	L	R
Appendix Surgery	Lumpectomy	L	R	Heart Transplant		
Gall Bladder Surg./Removal	Mastectomy	L	R	Liver Transplant		
Colon Surgery/Removal	Heart Valve Surgery					
Liver Surgery	Prostate Removal			**NONE**		
Heart Balloon/Stent	Spleen Removal					
Prostate Reduction	Skin Biopsy					

OTHER: _____

PAST EYE HISTORY: (please circle all that apply) **L = Left Eye R = Right Eye**

Contact Lenses	L	R	Macular Pucker/ERM	L	R	Ocular Migraine	L	R
Allergic conjunctivitis	L	R	Fuchs Dystrophy	L	R	Retina Tear	L	R
Narrow Angles	L	R	Glaucoma	L	R	"Crossed" Eyes	L	R
Blepharitis	L	R	"Lazy" Eye	L	R	Floaters	L	R
Cataract	L	R	Retina Detachment	L	R	Glasses		
Corneal dystrophy	L	R	Eye Injury	L	R			
Macular Degeneration	L	R	Diabetic retinopathy	L	R	**OTHER:**		
Dry Eyes	L	R				_____	L	R

PAST EYE SURGERY: (please circle all that apply)

			Year				Year				Year
Cornea transplant	L	R		Glaucoma Trab	L	R		YAG Cap	L	R	
DSEK Cornea Transplant	L	R		Retina Detachment Repair	L	R		Eye straightening	L	R	
Goniotomy	L	R		Vitrectomy Surgery	L	R					
Cataract surgery	L	R		Retina Injection	L	R					
Glaucoma Tube	L	R		LASIK/PRK	L	R		**OTHER**	L	R	
Glaucoma Laser SLT	L	R		Glaucoma Laser PI	L	R		_____	L	R	
Retina Laser	L	R		Retina Laser	L	R		_____	L	R	
Eyelid Surgery	L	R		Pterygium	L	R		_____	L	R	
Macular Hole Surg.	L	R									

PHARMACY INFO:
Name: _____
Tel Number: _____
Address: _____

PRIMARY CARE DOCTOR:
Name: _____
Tel Number: _____
Address: _____

MEDICATIONS: (Please list all current medications)

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

MEDICATION ALLERGIES: (Please list all allergies)

_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY: (Please circle all that apply)

CIGARETTE SMOKING:
- Never smoked
- Smokes daily
- Former smoker
  - Packs per day:
  - Total yrs of smoking: ___

ALCOHOL:
- Do not drink at all
- Less than 1 drink/day
- 1-2 drinks/day
- More than 3 drinks/day

DRIVING STATUS:
- Daytime Driving Y N
- Night Driving Y N

OCCUPATION:
_____

FAMILY HISTORY: (please circle all that apply) **M**=Mother **F**=Father **B**=Brother **S**=Sister

Blindness	M	F	B	S	Diabetes	M	F	B	S	**OTHER**	
Cancer	M	F	B	S	Glaucoma	M	F	B	S	_____	M F B S
Cataracts	M	F	B	S	Heart Disease	M	F	B	S	_____	M F B S
Stroke	M	F	B	S	Migraine	M	F	B	S		
Retinal Detachment	M	F	B	S							

ALERTS: Do you have any of the following? (Circle if YES)

Alert	OTHER:
Allergy to adhesive	
Allergy to lidocaine	
Allergy to Fluorescein	
Allergy to Dilation Drops	
Artifical Heart Valve	
Pacemaker	
Defibrillator	
Rapid heart beat with epinephrine	
Blood Thinners	
Artificial joints within past two years	
Premedication prior to procedures	
MRSA	
Pregnancy or planning a pregnancy	
Steroid responder--Eye Pressure	

REVIEW OF SYSTEMS: Are you currently experiencing any of the following? (Circle if YES)

Poor vision	Constipation	OTHER:
Eye pain	Burning with urination	
Tearing	Joint Pain	
Red Eyes	Joint Stiffness	
Jaw pain	Arthritis	
Scalp tenderness	Rash	
Loss of vision	Headache	
Fever	Seizure	
Chills	Stroke	
Unintentional Weight Loss	Paralysis	
Stuffy nose	Anxiety	
Ear Ache	Depression	
Dry mouth	Diabetes	
High Blood Pressure	Thyroid Problems	
Rapid Heart Beat	Bleeding	
Cough	Anemia	
Wheezing	Hay Fever	
Shortness of Breath	Hives	
Diarrhea		