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

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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:
_____

Have you had the pneumonia vaccine? Yes No

Have you had the COVID vaccine? Yes No

Do you have a healthcare proxy? Yes No

Do you have a living will? Yes No

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	Retinal Detachmt	M	F	B	S
Cancer	M	F	B	S	Glaucoma	M	F	B	S					
Cataracts	M	F	B	S	Heart Disease	M	F	B	S					
Stroke	M	F	B	S	Migraine	M	F	B	S					

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

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		