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

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)

Arthritis	Depression	High Cholesterol
Asthma	Diabetes	Lymphoma
Atrial fibrillation	Kidney Disease	Leukemia
BPH—Prostate Enlargemt	Epilepsy/Seizures	Colon Cancer
CVA—Stroke	High Blood Pressure	
COPD/Emphysema	HIV/AIDS	**NONE**

OTHER: ____

PAST SURGICAL HISTORY: (please circle all that apply)

Heart Artery Bypass
Colon Surgery/Removal

NONE

OTHER: ____

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

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

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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		Pterygium	L	R		______________	L	R	
Eyelid Surgery	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

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

Glaucoma M F B S

Retinal Detachment M F B S

Cataract Surgery Complications 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	
Artificial 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	