WOODCLIFF LAKE OPHTHALMOLOGY, LLP.

MARY MENDELSOHN, MD, FAAO
Comprehensive Eye Care & Medical Retina
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Comprehensive Eye Care, Cataract Surgery,
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ANNE MARIE ALINO, MD, FAAO
Comprehensive Eye Care, Cataracts,
Glaucoma, Macular Degeneration

NEW PATIENT CATARACT CONSULT QUESTIONNAIRE

Attached please find three forms to be completed.

It is important that you complete these forms prior to your visit and bring them with you to your cataract consult appointment, along with your insurance cards, a photo ID and a list of medications you are currently taking.

Please arrive one hour (60 minutes) earlier than your scheduled appointment time for pre-examination visual tests.

If you are a contact lens wearer, please refrain from wearing your lenses for three days prior to your appointment.

If you have any questions, please do not hesitate to call the office at (201) 782 -1700.

Thank you very much.

577 Chestnut Ridge Road, Lower Level, Woodcliff Lake, NJ 07677 • Tel. (201) 782-1700 • Fax (201) 782-1749 • www.bergeneye.com

Patient Name: _____ Date:_____

Circle which eye is being evaluated? RT LT BOTH

Do you take:

Flomax (Famsulosin)	Y	N
Rapaflo (Silodosin)	Y	N
Cardura (Doxazosin)	Y	N
Hytrin (Terazosin)	Y	N
Prazosin (Minipress)	Y	N
Dutasteride/Tamsulosin (Jalyn)	Y	N
Uraxatrol (Alfuzosin)	Y	N
Fenasteride (Propecia)	Y	N
Tolterodine (Detrol)	Y	N
Saw Palmetto	Y	N
Any OTC prostate medication	Y	N

Do you have difficulty, even with glasses, doing any of the following activities: (check all that apply)

Reading small print, such as labels
Reading a newspaper, book or cell phone
Reading a large print book
Recognizing people when they are close to you
Seeing steps, stairs, street signs or store signs
Writing checks or filling out forms

Do you experience: (check all that apply)

Poor night vision
Rings or halos around lights
Glare caused by headlights or bright sunlight
Hazy and/or blurry vision
Poor color vision

If you drive a car, please answer the following questions: (circle best answer)

How much difficulty do you have driving **during the day** because of your vision?
No difficulty Moderate amount of difficulty Great deal of difficulty

How much difficulty do you have driving **at night** because of your vision?
No difficulty Moderate amount of difficulty Great deal of difficulty

Cataract surgery can almost always be safely postponed until you feel that stronger glasses are not improving your vision anymore.
Do you feel that you need cataract surgery? Yes No

Signature:_____ Date:_____

PLEASE COMPLETE AND BRING WITH YOU TO YOUR APPOINTMENT

Outcome PQRS Patient ID: _____ Practice/Surgeon's Name: Alyson Yashar, MD

Site ID as seen in PQRS Registry: _____

Pre-Surgery Visual Functioning VF-8R Patient Questionnaire

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

1. Reading small print such as 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 ☐ Unable to do the activity
2. Reading a newspaper or book?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
3. Seeing steps, stairs or curbs?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
4. 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 ☐ Unable to do the activity
5. Doing fine handwork like sewing, knitting, crocheting or carpentry?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
6. 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 ☐ Unable to do the activity
7. Playing games such as bingo, dominos, card games or mahjong?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
8. Watching television?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity

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PRACTICE OPTIMIZATION

LIFESTYLE QUESTIONNAIRE

Name _____

There are a variety of options for cataract surgery that will not only give you clearer vision, but can also reduce your dependency on glasses. Each option has potential advantages and disadvantages, depending on your lifestyle and the activities you enjoy. Please help us to better understand what is important to you in order to determine which option is best suited for your lifestyle and eye health.

What is (or was) your occupation? _____

Please circle the following activities you do on a regular basis:

Read Newspapers/Books	Drive – Nighttime	Play a Musical Instrument	Use Cell Phone
Read Medicine Bottles	Shop	Dine in Restaurants	Watch Movies in Theatre
Needlepoint/Sew	Play Tennis	Bicycle	Photography
Crossword Puzzles	Hunt or Fish	Play Cards/Dominos	Cook
Participate in Water Sports	Paint/Draw	Use the Computer	Paperwork/Writing
Drive – Daytime	Watch Spectator Sports	Golf	Visit/Care for Grandchildren

Are you having difficulty with any of the activities listed above as a result of your vision? _____

How many combined hours per day do you spend on a computer, tablet, and/or smartphone? _____

Please share anything else you think might be important about your lifestyle or daily activities: _____

_____

_____

Are there times in your day that you wish you didn't have to wear glasses? Yes No

If yes, explain when: _____

Please place an "X" on each continuum where it best describes how you feel about the following:

Correction of near vision:
(e.g., reading, use of phone)
I want to wear glasses — I don't want to wear glasses

Correction of intermediate vision:
(e.g., using a tablet/computer)
I want to wear glasses — I don't want to wear glasses

Correction of distance vision:
(e.g., driving, watching television)
I want to wear glasses — I don't want to wear glasses

Patient signature _____

READY. SET. **GROW.**

Alcon A Novartis Division