Vision Preferences Checklist

Date _____ **Your Name** _____

We want to help you maintain excellent vision. One area of evaluation today will be cataracts, which refers to a cloudy lens within the eye. When a cataract is removed, a lens implant is used to replace the cloudy human lens. If it is determined that a lens exchange is appropriate, your answers will help us select an implant that best suits the vision demands of your lifestyle. Please fill this form out completely and we will discuss it with you during your exam.

❶ To better understand how your vision helps or hinders daily tasks, please rate your vision preferences at the following distances:

Distance Vision: driving, golf, tennis, other sports, watching TV.

- ☐ Prefer no distance glasses
- ☐ I wouldn't mind wearing distance glasses

Mid-range Vision: computer, menus, price tags, cooking, board games, seeing items on a shelf.

- ☐ Prefer no mid-range glasses
- ☐ I wouldn't mind wearing mid-range glasses

Near Vision: reading books, newspapers, magazines, doing detailed close work.

- ☐ Prefer no near glasses
- ☐ I wouldn't mind wearing near glasses

❷ Please check the single statement that best describes you in terms of **night vision:**

- ☐ Night vision is extremely important to me, and I require the best possible quality.
- ☐ I want to be able to drive comfortably at night, but I would tolerate some slight imperfections.
- ☐ Night vision is not important to me.

❸ If you **had to wear glasses after surgery for one activity**, for which activity would you be most willing to use glasses?

- ☐ Distance Vision
- ☐ Mid-range Vision
- ☐ Near Vision

❹ Does your vision fluctuate during the day?

☐ Yes ☐ No

❺ If you could have good distance vision during the day without glasses, and good near vision for reading without glasses, but the compromise was that you **might see some halos or rings** around lights at night, would that be OK?

☐ Yes ☐ No

❻ If you could have good distance vision and mid-range vision during the day and night without glasses, but the compromise was that you **might need glasses for reading** the finest print at near, would you like that option?

☐ Yes ☐ No

❼ How many hours per day do you spend:

_____ **On the computer**

_____ **Reading** books, newspapers, documents or small print

_____ **Driving during the day**

_____ **Driving at night**

❽ Please list favorite **hobbies or work** activities.

❾ Please place an "X" on the scale to **describe your personality** as best you can:

Easy going — **Perfectionist**

PATIENT HISTORY

REFERRING DOCTOR: _____

CONTACT INFORMATION

First Name:	Last Name:	DOB:	Gender: M F
Address:	City:	State:	Zip:

Phone:	E-mail:	Occupation:
Emergency Contact:		Emergency Phone:
Preferred Pharmacy:		

MEDICAL HISTORY

Do you have allergies? If yes, explain:
List <u>all</u> medications you take (including over the counter) or provide us a list:
Are you currently being treated for <u>any</u> medical condition? If yes, please explain:

FAMILY HISTORY

Is there a family history of eye disease? If yes, explain:					
Do you smoke? If yes, how much:			Do you drink? If yes, how much:		
Have you ever had or been told that you have?	**Yes**	**No**		**Yes**	**No**
Glaucoma			Diabetes		
Cataracts			High Blood Pressure		
Retinal Detachment/Disease			Heart Disease		
Lazy Eye/Amblyopia			Breathing Problems		
Eye Surgery			Auto-Immune Disease		
Dry Eye			Arthritis		
Eye Injury/Infection			Seasonal Allergies		
Other (list):					

EYE HISTORY

When was your last exam?	Doctors Name/City:	
How old are your current glasses?	Do you wear contacts? Yes	How old are your contacts?
How often do you use glasses?	Never Constantly Reading Only Distance Only Rarely	

SIGNATURE: _____ **DATE:** _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, assignment of payment, fee collection, and health care operations.

Person(s) Authorized to receive appointment reminders or medical information on your behalf (enter all that you approve):

Spouse:	**Parent:**	**Friend/Caregiver:**
_____	_____	_____

PRIVACY PRACTICES

I acknowledge the Notice of Privacy Practices of Wyoming Eye Surgeons is available for my review by request at the Front Desk.

PERMISSION TO BILL INSURANCE

I request that payment of authorized benefits be made on my behalf to Wyoming Eye Surgeons for any services furnished me by B. Michael Walker, MD or Wyoming Eye Surgeons. I authorize any holder of medical information about me released to the payer and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated on any approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In assigned cases, B. Michael Walker, MD or Wyoming Eye Surgeons agrees to accept the charge determination of the payer as the full charge, excluding non-covered services. Coinsurance and deductible are based upon the charge determination of the payer.

Name:_____**Signature:**_____**Date**:_____