McDonald Eye Associates

PATIENT CHECKLIST

Please read and fill out the enclosed forms and bring with you to your appointment with McDonald Eye Associates.

1. __________ Read enclosed letter

2. __________ Complete the remainder of the patient information sheet

3. __________ Answer the medical history questionnaire

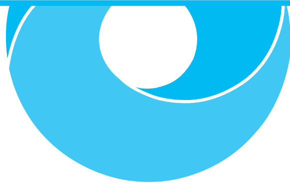
4. __________ Answer the vision questionnaire

5. __________ Make a list of questions you have for the doctor

6. __________ Please bring your insurance card with you to your appointment

If you have questions that you would like to discuss BEFORE your appointment, please call us at 479-521-2555 or 1-800-262-4405.

McDonald Eye Associates



3689 N. Steele Blvd.
Fayetteville, AR 72703
479.521.2555

5212 Village Pkwy, #6
Rogers, AR 72758
479.464.9702

www.mcdonaldeye.com

Dear Patient,

Your eye doctor has informed you that you have a cataract in one or both of your eyes and is referring you to McDonald Eye Associates for an evaluation and possible scheduling for cataract surgery.

Your eye doctor will make the appointment for you to visit us. Please take the time to review the enclosed information, as we feel this will be most helpful to you in preparation of your visit to our clinic.

When you arrive, there will be a thorough examination of your eyes. The exam will take a couple of hours, so please plan accordingly. We will need to dilate your eyes, which will require you to have someone to drive you home.

Once your examination is finished, you may choose to proceed with scheduling your surgery. One of our cataract surgery coordinators will meet with you and set a date and time for the procedure. They will tell you where to go for the surgery, what time to arrive, and will answer any questions regarding medications and insurance.

Having eye surgery is a very important decision, and at McDonald Eye Associates, we do not take it lightly. We hope to answer all of your questions by the end of your visit and put you at ease with the decision you've made.

Enclosed please find some forms to fill out prior to your visit with us. One form asks several questions about your vision, which will be helpful to us in understanding your vision problems. All other questions will be answered during your visit.

Thank you for trusting McDonald Eye Associates with the care of your eyes.

Sincerely,
The Doctors and Staff of McDonald Eye Associates

McDonald Eye Associates

CATARACT AND REFRACTIVE LENS EXCHANGE QUESTIONNAIRE

The term "cataract" refers to a cloudy lens within the eye. When a cataract is removed, it is replaced with an artificial lens. Some clear lenses that have not yet developed cataracts are removed to reduce or eliminate the need for glasses. If surgery is appropriate for you, this questionnaire will help us provide the best treatment for your visual needs. It is important to understand that many patients still need glasses for some activities after surgery. Please fill this form out completely. If you have questions, please let us know and we will assist you with this form.

1. After surgery, would you be interested in seeing well **without glasses** in the following situations?
   Distance Vision (driving, golf, tennis, other sports, watching TV)
   ___ I prefer no Distance glasses. ___ I wouldn't mind wearing Distance glasses.

   Mid-range Vision (computer, menus, price tags, cooking, board games, items on a shelf)
   ___ I prefer no Mid-range glasses. ___ I wouldn't mind wearing Mid-range glasses.

   Near Vision (reading books, smartphones, tablets, e-readers, sewing, detailed handwork)
   ___ I prefer no Near glasses. ___ I wouldn't mind wearing Near glasses.

2. Please check the **single** statement that best describes you in terms of **night vision**:
   ___ a. Night vision is extremely important to me, and I require the best possible quality night vision.
   ___ b. I want to be able to drive comfortably at night, but I would tolerate some slight imperfections.
   ___ c. Night vision is not particularly important to me.

3. 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**

4. Some people prefer to hold their reading material very close, while others prefer holding their reading material much farther away, in their laps. The length of this sheet of paper from top to bottom is 11 inches. Using this sheet of paper as a very rough ruler, try to **estimate approximately** how far from your face you prefer to hold your reading material. Please place an "X" on the following scale to provide a very rough estimate as best you can:

11 inches --- 16.5 inches --- 22 inches
(1 paper length) (1 and a half paper lengths) (2 paper lengths)

5. If you could have **good Distance, Mid-range, and Near Vision all without glasses**, but the compromise was that you might see some **halos, rings, or starbursts** around lights at night, would you like that option? ____Yes ____No

6. If you could have **good Distance and Mid-range Vision without glasses**, but the compromise was that you might need glasses for the finest print at **near**, would you like that option? ____Y ____N

7. If you have a cataract and would like to reduce or eliminate the need for glasses, insurance may cover a significant portion of your overall procedure cost. Would you be interested in learning more about this option?
   ____Yes ____No ____Maybe, it depends on how much is covered by insurance

8. Please place an "X" on the following scale to describe your personality as best you can:

[---|---]
Easy Going Perfectionist

Please Sign Here________________________________

McDonald Eye Associates

VISION QUESTIONNAIRE

In order to help us better understand the problems you may be having due to your vision, please answer the following questions prior to your appointment at McDonald Eye Associates.

Due to your vision, are you currently having problems with: (mark once each line)	Always	Sometimes	Rarely	Never
Glare or starbursts around lights at night?	______	______	______	______
Decreased night time vision?	______	______	______	______
Seeing rings or halos around car headlights?	______	______	______	______
Hazy, filmy, or blurry vision?	______	______	______	______
Difficulty reading in dim lighting?	______	______	______	______
Are you concerned about falling?	______	______	______	______
Feeling that poor vision has decreased your independence?	______	______	______	______
ARE YOU ABLE TO:				
Read newspapers, phone books, etc.?	______	______	______	______
Recognize people across a parking lot?	______	______	______	______
DO YOU HAVE TROUBLE:				
Seeing curbs or steps?	______	______	______	______
Reading traffic signs before you go by them?	______	______	______	______
Attending church or other social activities at night?	______	______	______	______
With car headlights blinding you?	______	______	______	______
Doing hobbies you once enjoyed?	______	______	______	______
Driving while facing the sun?	______	______	______	______
Reading labels on jars or cans when shopping?	______	______	______	______
Do you find yourself frequently cleaning your glasses, because it seems that you are looking through a film?	______	______	______	______

Patient Signature ______________________________ Date ____________

McDonald Eye Associates

YOUR MEDICAL HISTORY

Patient name: ___________________________________

Please list any medications or food that you are allergic to:

____ ____
____ ____
____ ____
____ ____

List the *current* medications and dosage that you are taking:

____ ____
____ ____
____ ____
____ ____

Do you use any tobacco products? ________
If so, what type of tobacco products do you use and how often? ___________________________

Do you use any alcohol products? ________
If so, how often? ___________________________

Please circle all medical problems you have or have had:

Arthritis
Asthma
Bleeding tendency
Cancer (type) ______________________
Chronic Obstructive Pulmonary Disease (COPD)
Congestive Heart Failure (CHF)
Diabetes
Emphysema
Heart disease
High blood pressure
High cholesterol
Hypoglycemia
Lupus
Mitro Valve
Prostate trouble
Seizure disorder
Shortness of breath
Stroke
Thyroid trouble
Ulcers

Please circle all surgeries *you* have had:

Adenoids
Angioplasty
Appendectomy
Back surgery
Bladder surgery
Caesarian surgery
Cancer surgery (type) ______________________
Carotid artery
Carpal tunnel
Colon surgery
Ear surgery
Eye surgery (type) ______________________
Face lift
Gallbladder
Heart bypass
Hemorrhoidectomy
Hernia repair
Hip replacement
Hysterectomy
Kidney surgery
Knee replacement
Lumpectomy
Lung surgery
Mastectomy
Ovaries removed
Pacemaker
Prostate surgery
Thyroidectomy
Tonsillectomy
Tubal ligation
Vasectomy
Other ______________________

FAMILY MEDICAL HISTORY

Please circle all medical problems any blood relative has or has had:

Arthritis
Blindness
Cancer (type) ______________________
Cataracts
Crossed Eyes
Diabetes
Glaucoma
Heart problems
High blood pressure
Retinal detachment
Thyroid problems
Other ______________________

Thank you for taking the time to answer these questions for us. Please use the space below to list any questions you may have.

McDonald Eye Associates

NWA SURGERY CENTER