Dear Patient,

Welcome and thank you for choosing Clemson Eye, a leader in advanced eye surgery. Our eye surgeons are all American Board Certified Ophthalmologists and have together performed over 100,000 cataract and microsurgical procedures. Modern cataract surgery is a pain-less, stitch-less, fast procedure with almost immediate recovery.

While we perform both laser and traditional cataract surgery, laser cataract surgery with advanced lens implants can dramatically improve your post-operative eyesight, regardless of your age. Recent advances in technology allow us to achieve things in cataract surgery we wouldn’t have dreamed possible a few short years ago. Please read the enclosed brochure carefully and pay close attention to the information about preparing for your exam.

Please complete the enclosed forms and give them to the receptionist when you arrive.

Also, bring with you:
- Eye glasses and/or contact lenses you currently use
- Medical and/or Vision Plan Insurance cards (including primary policy holder information)
- Referral letter, if required by your insurance
- Photo identification
- Form of Payment
- List of Medications

A cataract exam is extensive and takes about 2 to 3 hours. If you have time restrictions, please let us know prior to your appointment. Your eyes will be thoroughly examined by the doctor, and several diagnostic tests will be performed. You are encouraged to bring a friend/family member with you. Throughout this evaluation, we will determine if you are a candidate for a cataract procedure, if you are ready, then you will leave us knowledgeable and prepared for the operation. Your pupils may be dilated, causing temporary blurriness and light sensitivity that can last for several hours. Please exercise caution if you are driving and wear sunglasses or have someone transport you.

Upon completion of your exam, covered charges for our services will be billed directly to your medical insurance provider. You will be responsible for paying for any co-pays, co-insurance, deductibles, and non-covered services. You will meet with a cataract counselor who will explain all aspects of the financial situation before any final decisions are made. We accept cash, check and credit cards. Payment plans are available for higher balances. We look forward to serving you soon!

Your Clemson Eye Family
Patient Name: ________________________________

Birth Date: ____________________________ Today's Date: ____________________________

Past Medical History

☐ None Apply    ☐ Atrial fibrillation    ☐ Hepatitis C    ☐ Seizures
☐ Allergies    ☐ Benign Prostatic Hypertrophy    ☐ High blood pressure    ☐ Sleep apnea
☐ Anemia    ☐ Coronary artery disease    ☐ High cholesterol    ☐ Stroke
☐ Anxiety    ☐ Dry Eye    ☐ Irritable bowel syndrome    ☐ Thyroid disease
☐ Arthritis    ☐ GERD    ☐ Kidney disease
☐ Asthma    ☐ Heart attack    ☐ Migraines

☐ Flu Shot Date Rcvd: ____________________________

☐ Diabetes    ☐ Oral    ☐ Insulin    ☐ Diet-controlled    A1C _________ Yr. of Diagnosis: ____________

Past Surgical History

☐ None Apply    ☐ Cataract Surgery    ☐ Pacemaker    ☐ Right    ☐ Left    ☐ Both
☐ Angioplasty    ☐ Cornea Transplant    ☐ Shunt Tube
☐ Angio w/stents    ☐ Heart Bypass    ☐ Thyroid Surgery    ☐ Right    ☐ Left    ☐ Both
☐ Back Surgery    ☐ LASIK

Glaucoma laser in:
Laser of retinal tear in:
Retina surgery in:

Family History: Please indicate if you mother, father, or sibling(s) have or had any of the following:

☐ Family History Unknown
☐ No Relevant Family History

Mother  ☐  Father  ☐  Sister(s)  ☐  Brother(s)

☐ Cataract
☐ Glaucoma
☐ “Lazy Eye”
☐ Macular degeneration

Allergies

☐ No Known Allergies    ☐ Moxifloxacin    ☐ Prolensa    ☐ Sulfa
☐ Amoxicillin    ☐ Non-steroidal (Aleve, ibuprofen)    ☐ Tetracycline    ☐ Vancomycin
☐ Latex    ☐ Penicillin    ☐ Tobramycin

Other: ____________

Patient Signature ____________________________  Tech Signature ____________________________
Authorization for Use

Patient Name: ___________________________ Date: ______________

SSN: ___________________________ DOB: ______________

Release records from: ___________________________

Email: ___________________________

I authorize the custodian of records of: ___________________________ or other person/entity (specifically describe) to disclose/release all medical records to: ___________________________

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Please send the records to: Clemson Eye Clinic (circled) at the fax number below:

Anderson(Gville St) (864) 622-5020
Anderson (Fant St) (864) 225-1139
Clemson (864) 654-3275
Clinton/Laurens (864) 833-0520
Easley (864) 855-6850

Greenville (Halton) (864) 987-0036
Greenville (Pelham) (864) 292-2020
Greenville (Lasik) (864) 297-8777
Newberry (803) 276-4536
Powdersville (864) 295-3242

Simpsonville (864) 967-8582
Williamston (864) 847-6060

Disclosure of Protected Health Information

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Name: ___________________________ Signature: ___________________________ Date: ______________

Patient / Guardian / Guarantor

Name: ___________________________ Signature: ___________________________ Date: ______________

Witness
Have you ever been diagnosed with Dry Eye Disease or Ocular Surface Disease?  
☐ Yes  ☐ No  When?  

1. Have you used artificial tears in the last two hours?  ☐ Yes  ☐ No

2. Do you have any of the following symptoms?

☐ Redness  ☐ Scratchy feeling of sand or grit in the eye
☐ Burning  ☐ Itching
☐ Light sensitivity  ☐ Excess tearing / watering eyes
☐ Tired eyes, eye fatigue  ☐ Stringy mucus in or around the eyes
☐ Foreign body sensation  ☐ Contact lens discomfort
☐ Fluctuating vision

Report the FREQUENCY of symptoms you are experiencing by using the numbering system below:

1 = Sometimes  2 = Often  3 = Constant

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dryness, Grittiness or Scratchiness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soreness or Irritation</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Burning or Watering</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Fatigue</td>
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<td></td>
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</tr>
</tbody>
</table>

3. Are you being treated for any of the following conditions?

☐ Diabetes  ☐ Thyroid Condition
☐ Arthritis ☐ Sjögren's Syndrome
☐ Lupus    ☐ Rosacea
☐ Dry Eye  ☐ Blepharitis

** For Office Use Only**

Doctor Signature: _____________________________ Date: ________________

Technician: _______________________________

Tear Osmolarity: OD: ________________________ OS: ________________________
### Your Information

Name: ___________________________ DOB: ____________

Pharmacy Name: ___________________ Pharmacy Address: ___________________

### Visual Functioning

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

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>Somewhat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading small print, pill bottle labels, newspapers, books or the telephone book?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Seeing steps, stairs or curbs?</td>
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<tr>
<td>Reading traffic signs, street signs or store signs?</td>
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<tr>
<td>Doing fine handwork like sewing, knitting or carpentry?</td>
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<tr>
<td>Writing checks or filling out forms?</td>
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<tr>
<td>Playing games such as bingo, dominos or card games?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shaving or putting on your make up?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooking?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do a lot of close detail work?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you use a computer frequently?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you do a lot of night driving?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

On a scale of 1-5 (where 1 is none and 5 is a great deal), how much difficulty do you have driving:

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day driving</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Night driving</td>
<td></td>
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</table>

### Symptoms

**Have you been bothered by:**

<table>
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<th>Symptom</th>
<th>Yes</th>
<th>No</th>
<th>Somewhat</th>
</tr>
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<td>Poor night vision, color vision or double vision?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hazy and/or blurry vision?</td>
<td></td>
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<tr>
<td>Seeing well in poor or dim light?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you currently drive a car?</td>
<td></td>
<td></td>
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<tr>
<td>Seeing rings or halos around light at night while driving?</td>
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<td></td>
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<tr>
<td>Glare caused by headlights or bright sunlight?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Do you do a lot of night driving?</td>
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<td></td>
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</tbody>
</table>

### Lifestyle Considerations?

**Occupation:** ___________________________  
Currently Working ☐  Retired ☐

List your favorite hobbies, sporting / recreational / outdoor activities:

**Do you use a computer frequently?**

Yes ☐  No ☐  Somewhat ☐

**Do you do a lot of close detail work?**

Yes ☐  No ☐  Somewhat ☐

**Have you ever tried monovision contact lenses?**

Yes ☐  No ☐  Somewhat ☐

If “yes”, did/do you like it?

Yes ☐  No ☐  Somewhat ☐

**Do you wear progressive/no-line bifocals now?**

Yes ☐  No ☐

**Over your lifetime, have you generally been satisfied with your vision with prescription glasses?**

Yes ☐  No ☐  Maybe ☐

If “no”, please explain:

**Would you like to have, without glasses, good distance and near vision in good light, even if you might see some rings around lights at night?**

Yes ☐  No ☐  Maybe ☐

**Have you had LASIK?**

Yes ☐  No ☐

**Do you have any specific vision concerns?**

__________________________

Cataract Surgery is optional.  

**Based on your vision, do you want to have cataract surgery?**

Yes ☐  No ☐

Name (print): ___________________________  Date: ____________

Signature: ___________________________