Lubbock Eye Clinic
& OPTICAL CENTER

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PRE-OP INFORMATION

MUST BRING TO PRE-OP APPOINTMENT!

Name: _____ **Date of Birth:** _____

Address: _____

Primary Phone #: _____ **Secondary Phone #:** _____

Medical History: Please circle any that apply to you.

Apnea
Arthritis
Arrhythmia
Asthma
Back Problems
Birth Defect
Bleeding Disorders
Brain Damage
Bronchitis
Cancer
Cerebral Palsy
Chest Pain
Cholesterol
Congestive Heart Failure
Diabetic? ☐ Y ☐ N
Use Insulin? ☐ Y ☐ N
Recent A1C: _____
Dialysis
Depression
Emphysema
Fainting
Gastric Ulcers
Glaucoma
Hay Fever
Heart Attack
Hepatitis
Heart Disease
Heart Murmur
High Blood Pressure
Hiatal Hernia
HIV / AIDS
Hypoglycemia
Intestinal Disorders
Kidney Problems
Lupus
Migraines
Mitral Valve Prolapse
Multiple Sclerosis
Neurological Disorders
Pacemaker
Phlebitis
Psychiatric Disorder
Scoliosis
Seizures
Seizure Disorders
Sickle Cell Disease
Stroke
Thyroid Disease
TB

Have you had any recent respiratory infections, other types of infections, or hospitalizations? ☐ Yes ☐ No
If yes, please describe and list date: _____

Do you use: Alcohol: ☐ Yes ☐ No Tobacco: ☐ Yes ☐ No Caffeine: ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list: _____

Have you ever undergone surgery? ☐ Yes ☐ No (If yes, please list ALL surgeries below.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you take aspirin or blood thinners? ☐ Yes ☐ No (If yes, please fill in information below.)

Cardiologist's Name: _____

Phone #: _____ Fax #: _____

Primary Care Physician's Name: _____

Phone #: _____ Fax #: _____

Please list ALL medications:

Medication	Dosage & Frequency	Associated Diagnosis
EXAMPLE: Atorvastatin	10mg, 2 times a day	High Cholesterol

If you already have a list of your medications, you can submit a copy to: **lec.techs03@gmail.com**

Please: Include your full name and date of birth in the email!

Patient: _____ DOB: _____

Pre-Cataract Surgery - Visual Functioning Index (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	

Patient Signature: _____ Today's Date: _____