HENRY EYE CLINIC

"Compassionate, competent eye care for generations"

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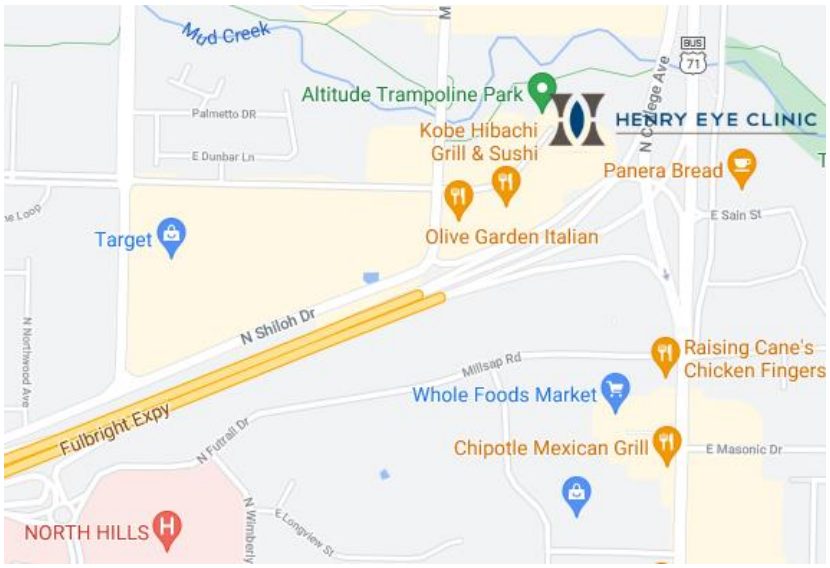
Dear Patient,

Welcome to the Henry Eye Clinic. We are honored you chose us for your cataract surgery consultation. The Henry Eye Clinic has been providing quality eye care and eye surgery for Northwest Arkansas for almost 90 years. We are fortunate to live in a time where cataract surgery is undergoing many remarkable advances, and we at Henry Eye Clinic pledge to offer our cataract patients the most advanced and up to date surgical technology. This cataract packet was designed to aid you in making a decision regarding your cataract surgery options.

We realize how important your vision is to you. We want to know about your overall health as well as how you use your vision on a daily basis and which activities you enjoy. This information, along with your eye exam, will help us recommend intraocular lenses that will best fit *your* lifestyle.

Please read this material carefully, fill out the questionnaires, and bring them to your preoperative appointment. On the day of your preoperative visit, we will measure your eyes for cataract surgery, have a thorough exam with your surgeon, review surgical instructions, pick your intraocular lens, and schedule your surgeries. Your preoperative visit will be a longer clinic visit, around two to three hours, and does require dilation of your eyes, so please be prepared accordingly.

Thank you for trusting us with your vision. We truly care about you and will do everything possible to help you see clearly once again.



Frequently Asked Questions

What is a cataract?

The natural "lens" in the eye focuses the light on objects so that we can see clearly. Like the lens in a camera, it brings our world into focus at different distances. As we age, the natural lens becomes cloudy, discolored, and stiffer, which is then called a "cataract." This is also part of the reason why most people need reading glasses after around forty years of age, called "presbyopia."

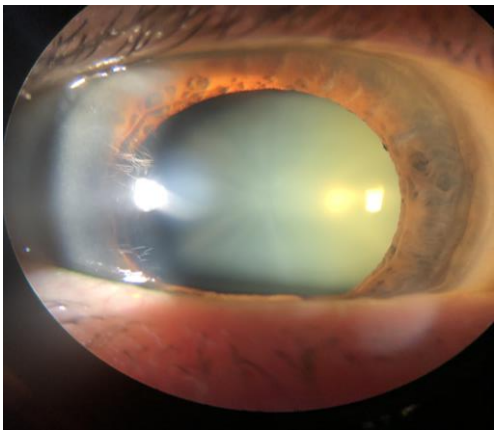


Photo above shows a cataract, the yellow haze you see within the pupil

What are the symptoms of a cataract?

- Hazy, cloudy, or blurry vision
- Needing more light to see clearly than you used to require
- Rings or halos around lights
- Trouble adjusting to different lighting conditions
- Poor night vision or difficulty driving at night
- Sensitivity to light, glare, or headlights
- Dimness of vision that can no longer be improved sufficiently with glasses or contacts
- Feeling like glasses are dirty despite cleaning them or changing prescriptions

When do I need cataract surgery?

Even if you have been diagnosed with cataracts, you are not required to have cataract surgery. When you feel your decreased vision is affecting your day to day life, it may be time to consider cataract surgery.

What is cataract surgery?

Small incisions, less than 3 millimeters in size, are made in the front, clear part of the eye called the cornea. An instrument is inserted and uses sound waves to break up the cataract and vacuum it from the eye. A new artificial lens (intraocular lens, or IOL) is put in its place.

Simulated vision: Left: blurry without details before cataract surgery; Right: after surgery, crisp

Does cataract surgery hurt?

We use a combination of numbing drops and medications to help you remain comfortable and relaxed during the surgery. During the surgery, most patients only notice lights changing colors. You will have an IV placed and we use a medication that takes away the pain and relaxes you, but allows you to continue breathing on your own. After surgery, most patients are very

comfortable and only notice mild irritation that does not require pain medication outside of occasional Tylenol.

How long does surgery take?

Generally less than fifteen minutes, but because you will receive medications through your IV, you will need a driver, and the entire process will take a few hours. You will go home the same day shortly after the procedure.

Where is the surgery performed?

We typically operate at North Hills Surgical Center which is located at 3271 Wimberly Drive, Suite 1, in Fayetteville, Arkansas, near the Washington Regional Medical Center.

When and where are my post op visits?

You will generally be seen the next day, within the next week, and about a month after surgery back at the Henry Eye Clinic. If you were referred by your optometrist, you will typically see them a week or two after the second eye for co-management.

When can I have surgery on my second eye?

Typically, two weeks after the first eye. Some patients heal a bit slower so we can push out the surgery until the first eye is healed enough to allow you to function with the first eye's vision.

When can I drive and go back to work?

Most patients see and feel well enough to go back to work the next day and can drive if they feel safe doing so, provided they have legal driving vision in the other, non-operative eye.

When can I get fitted for new glasses or contacts?

Typically, a month after surgery on the second eye.

What are the risks?

Although cataract surgery is generally very safe and effective, there are still risks that include bleeding, retinal swelling, infection, loss of vision, and need for further surgery.

What are my restrictions after surgery?

For the first week, you will sleep with an eye shield at night, do no lifting over ten pounds, wear no eye makeup, and do no vigorous exercise. We ask that you avoid dunking your head under water for two weeks. You are free to read, watch TV, and do your other normal activities immediately after surgery, but ask that you do not rub the eye.

When do I need to stop wearing my contact lenses?

Stop wearing contacts two weeks before your preoperative appointment.

What about my dry eyes?

Dry eyes can affect measurements for cataract surgery so we recommend using scheduled artificial tear drops four times a day for a week or two leading up to your preoperative appointment.

Can my cataract come back?

After removal of the cataract, it cannot return. However, during the surgery, we replace your old lens with a new lens and place it inside a capsular bag. Over time, the capsular bag can become cloudy and is known as a "secondary cataract" or "posterior capsular opacification." These can be treated in clinic with a brief, painless laser procedure by your surgeon.

Will I need to wear glasses after cataract surgery?

This depends on your eye and your choice of lens. We do, however, offer several options that can reduce or even eliminate the need for glasses or contacts after surgery. During your pre-operative visit, you will have measurements to calculate the correct power lens to be placed in your eye during cataract surgery. Depending on your overall eye health, you may have these lens options:

- **Monofocal lens:** Full time glasses are generally needed after surgery to see clearly at all distances.
- **Monovision:** One eye is set for near vision; one eye set for distance vision. You must have tried this before in glasses or contacts for this to be an option because some patients to not adapt well to this change and feel off balance.
- **Toric lens:** Corrects corneal astigmatism (where the clear covering of the eye is shaped more like a football than a basketball) to allow clearer distance vision, so most patients can drive without glasses, and only need over the counter "cheaters" to read.
- **Multifocal/Trifocal/EDOF lens:** These advanced technology lenses can correct corneal astigmatism AND presbyopia at the same time as your cataract surgery, giving you the best opportunity to have freedom from glasses at distance, intermediate, and near. Not an option if you have diabetic retinopathy, macular degeneration, or other retinal issues

Is cataract surgery covered by my insurance?

Medicare and other insurances will ***only*** pay for the Monofocal lens option, but will allow you to pay the additional "out of pocket" charge for the other options to give you the once in a lifetime opportunity to have the best chance at freedom from glasses at the same time as your cataract surgery. You will discuss your options and preferences with your surgeon at your preoperative visit.

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Vision Preferences

Your name _____ Date _____

Do you wear glasses or contacts now?

- ☐ Yes: If yes: Do you wear them for distance vision, to read, or all the time?
  - ☐ Distance ☐ To read ☐ All the time
- ☐ No

Have you ever had "monovision?" (one eye sees well at distance and the other eye sees well for near vision)

- ☐ Yes: If yes, did you like it? _____
- ☐ No

Are you interested in seeing well without glasses or contacts?

- ☐ Yes, I would prefer to not wear glasses or contacts
- ☐ No, I would not mind wearing glasses or contacts

After cataract surgery, which would you prefer?

- ☐ Full time glasses
- ☐ Part time glasses: ☐ For reading ☐ For computer ☐ For distance
- ☐ I would prefer to be free from glasses and contacts as much as possible

What is your job (if retired, what was your previous job)? _____

What are some of your hobbies? (check all that apply)

☐ Reading ☐ Hunting ☐ Golfing ☐ Tennis ☐ Sewing/crafts
☐ Cycling ☐ Skiing ☐ Cooking ☐ Watching TV ☐ Other_____

Please place an "X" on the following scale to describe your personality:

Easy going — Moderate — Perfectionist

Are you willing to see occasional "rings" in your vision if you are able to get out of glasses most of the time, at distance, intermediate, and near?

- ☐ Yes (multifocal/trifocal/EDOF lenses may be an option for you)
- ☐ No

Are you willing to consider paying an "out of pocket cost" for your intraocular lens to have a greater chance of not needing glasses after surgery?

- ☐ Yes
- ☐ No
- ☐ Maybe, I would like more information

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Cataract Symptoms Checklist

Your name _____ Date _____

Does your vision make it difficult for you to: (check all that apply)
- ☐ Read a newspaper
- ☐ Read a menu
- ☐ Read traffic signs
- ☐ Drive in bright sunlight
- ☐ Drive at night due to glare from headlights
- ☐ Walk downstairs
- ☐ See objects in the shade when in the sunshine
- ☐ Sewing or doing needle work
- ☐ Recognize faces from across the room
- ☐ Other: _____

Which cataract symptoms do you have? (check all that apply)
- ☐ I feel my vision is not as clear as it used to be
- ☐ I avoid driving in certain situations because I can't see well
- ☐ I need brighter lights to see than I used to need
- ☐ I feel my glasses are not "good enough" anymore
- ☐ Colors aren't as bright as they were in the past
- ☐ I have poor night vision
- ☐ Other: _____

How much are cataracts affecting your daily life? (circle one)

None Mildly Moderately Severely

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5

Have you ever had surgery on your eyes?
- ☐ Yes: What kind? Circle one: LASIK PRK LASEK RK Retinal Strabismus
- ☐ No

Are you ready to have surgery to remove your cataracts?
- ☐ Yes
- ☐ No, I would prefer to wait

Dry Eyes Screening: Do you experience:
- ☐ Watery Eyes ☐ Blurry Vision ☐ Burning ☐ Dryness ☐ Redness
- ☐ Stinging ☐ Irritation ☐ Grittiness ☐ Feel like something in eye
- ☐ Need to blink to clear vision ☐ Other: _____

Do you use tear drops (artificial tears) currently? ☐ Yes ☐ No

Have you ever used the medication "Flomax?" ☐ Yes ☐ No

Name:_____ **Date of Birth:**_____ **Today's Date:** _____

Referred by: _____ Name of optometrist: _____

Past Medical History: PCP: _____ Preferred Pharmacy: _____

Last Eye Exam Date: _____ Do you wear: ☐ Glasses ☐ Contacts ☐ Both ☐ None

Please mark any condition you have now or in the past: ☐ **NONE**

- ☐ Dry Eyes
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Glaucoma
- ☐ Keratoconus
- ☐ Lazy Eye/Amblyopia
- ☐ High Blood pressure
- ☐ Arrhythmia
- ☐ Heart Attack/Stents Date: _____
- ☐ Arthritis: ☐ Rheumatoid ☐ Osteoarthritis
- ☐ Asthma
- ☐ COPD
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Diabetes: Type: _____

  Most Recent Blood Sugar: _____ Date: _____

  HbA1c: _____
- ☐ LDL (High Cholesterol)
- ☐ Cancer
- ☐ Other: _____
- ☐ Other: _____

Family History: ☐ **NONE** ☐ Adopted

Please mark any conditions your family members or blood relatives have now or in the past:

- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Keratoconus
- ☐ Retinal Detachment
- ☐ Blindness
- ☐ High Blood pressure
- ☐ Heart Problems
- ☐ Arthritis: ☐ Rheumatoid ☐ Osteoarthritis
- ☐ Lung Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Diabetes: ☐ Type I ☐ Type II
- ☐ High Cholesterol (LDL)
- ☐ Cancer
- ☐ Other: _____

Have you had your: ☐ Flu vaccine: Date: _____ ☐ Pneumococcal Vaccine: Date: _____

Height: _____ Weight: _____

Review of Systems: ☐ **NONE** Circle all that apply Other:

Allergy/Immunologic:	Seasonal Allergies / Immunodeficiencies	
Cardiovascular:	Chest pain / Heart Failure / High blood pressure / Arrhythmia	
Constitutional:	Fatigue / Fever / Weight loss	
Ear/Nose/Mouth/Throat:	Deafness / Dry Mouth / Runny Nose / Sinus infection	
Endocrine:	Excessive thirst / Mood swings / High blood sugar	
Eyes:	Double vision/ Eye Pain / Vision loss / Glare / Flashing Lights Floaters / Dry Eyes / Watery Eyes / Light Sensitivity / Red Eye Itchy Eyes/ Trouble reading / Trouble Driving / Loss of Vision	
Gastrointestinal:	Constipation / Diarrhea / Hepatitis / Ulcers / Vomiting	
Genitourinary:	Blood in urine / Discharge / Genital Ulcers / Kidney stones	
Hematologic/Lymphatic:	Easy bleeding / Recurrent Infections / Easy Bruising	
Integumentary (Skin):	Eczema / Rashes / Itching / Poor wound healing / Jaundice	

Musculoskeletal:	Joint aches / Pain / Paralysis / Stiffness/ Swelling	
Neurological:	Alzheimer's / Dementia / Fainting / Headaches / Migraines / Numbness / Parkinson's / Seizures / Stroke	
Psychiatry:	Anxiety / Depression / Memory loss / Sleeping problems	
Respiratory:	Asthma / Shortness of breath / COPD / Bronchitis	

Social History:

Do you smoke? ☐ No ☐ Former Smoker ☐ Yes: Start Date:_____ Packs per Day:_____

Do you drink alcohol? ☐ No Yes: ☐ Beer ☐ Wine ☐ Spirits ☐ Former Drinker

How Often? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Socially

Allergies: (to medications or food) ☐ **NONE**

_____(Reaction:_____) _____(Reaction:_____)

_____(Reaction:_____) _____(Reaction:_____)

Ocular Medications: ☐ **NONE**

_____ ☐ Both eyes ☐ Right eye ☐ Left eye How Often_____

_____ ☐ Both eyes ☐ Right eye ☐ Left eye How Often_____

Systemic Medications (including over the counter): ☐ **NONE** ☐ See Attached list

_____Dose _____ Route _____ How Often_____

_____Dose _____ Route _____ How Often_____

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_____Dose _____ Route _____ How Often_____

Ocular Surgeries/Procedures: (ex: LASIK, RK, Cataract, Retina, Glaucoma, Lasers, Strabismus) ☐ **NONE**

_____ ☐ Both eyes ☐ Right eye ☐ Left eye Approx Date: _____

_____ ☐ Both eyes ☐ Right eye ☐ Left eye Approx Date: _____

_____ ☐ Both eyes ☐ Right eye ☐ Left eye Approx Date: _____

Surgeries/Procedures: (ex: gallbladder, hysterectomy, appendectomy, hip replacement, etc) ☐ **NONE**

_____(Date:_____), _____(Date:_____)

_____(Date:_____), _____(Date:_____)

_____(Date:_____), _____(Date:_____)

I affirm the information I provided regarding my medical and patient information to be complete and accurate to the best of my knowledge. I understand and agree regardless of insurance status, that I am responsible for the balance on this account for any professional services rendered.

Signature: _____Printed Name:_____ Date: _____

Patient Information: *We are NOT providers for any Vision Plans*

Full Legal Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security: _____- _____- _____Employer: _____Employer Phone: _____

Home Phone: _____Cell Phone: _____

Email: _____ Preferred contact: ☐ Home ☐ Cell ☐ Email

Sex: ☐ Male ☐ Female Gender Identity: _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/ Pacific Islander ☐ Latin American ☐ White
☐ Decline to Specify ☐ Other: _____

Ethnicity: ☐ African American ☐ American ☐ American Indian ☐ Chinese
☐ European American ☐ Hispanic/Latino ☐ Jewish ☐ Not Hispanic/Latino
☐ Unknown ☐ Decline to Specify

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Minor

Language: ☐ English ☐ Spanish ☐ Marshallese ☐ Sign Language ☐ Other: _____

Emergency Contact: _____ Relationship _____ Phone_____

Responsible Party/Guarantor: (if patient is less than 18 years old or covered by parents' insurance):

Name of Father _____ Date of Birth _____ Phone _____

Father's Employer _____ Phone_____

Name of Mother _____ Date of Birth _____ Phone _____

Mother's Employer _____ Phone_____

Medical Insurance_____ Policy #_____ Group # _____

Name of Policyholder _____Relationship_____

Birthdate of Policyholder _____Social Security # of Policyholder _____

Secondary Insurance Provider_____ Policy #_____ Group # _____

Birthdate of Policyholder _____Social Security # of Policyholder _____

Release of Information, Privacy Practices, and Financial Agreement

Please list those to whom we may discuss your diagnosis and treatments. I authorize Henry Eye Clinic to discuss my medical information with the following people:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I authorize Henry Eye Clinic physicians and staff to examine me (or my child), including dilation and diagnostic testing as necessary. I have been provided access to the "Notice of Privacy Policies" and I agree to the Henry Eye Clinic Financial Agreement.

Signature: _____ Date: _____