Patient Name: _____ DOB: _____ Date of Surgery: _____

Specific activity limitations and/or participation restrictions as stated by patient: _____

_____

Medical and Surgical History: _____

_____

☐ NKDA ☐ Known Allergies, list: _____

Current Medications: _____

_____

Physical Examination

Date of Exam: _____
(Must be within 30 days of procedure)

	Normal	Abnormal	Elaborate Abnormal Findings
Heart	☐	☐	_____
Lungs	☐	☐	_____
Eyes	☐	☐	_____

Plan/Proposed Surgery: _____

1. Best corrected visual acuity	**Right Eye**	**Left Eye**
Distance	_____	_____
Near (if complaint is near)	_____	_____

2. Other ancillary tests and results if done: _____

3. Please certify that your office chart supports these statements by initialing each:

_____ The patient's impairment of visual function is believed not to be corrected with a tolerable change in glasses or contact lenses.

_____ Cataract in the operative eye is believed to be significantly contributing to the patient's visual impairment.

_____ The patient desires surgical correction; the risks, benefits, and alternatives have been explained; and a reasonable expectation exists that lens surgery will significantly improve both the visual and functional status of the patient.

Physician's signature: _____ **Date:** _____ **Time:** _____ ☐ am ☐ pm

Patient Label
placed here

WakeMed
Cataract H & P