BERGEN-PASSAIC
CATARACT SURGERY & LASER CENTER, INC

# OCULAR HISTORY

Patient: ________________________________________ DOB: ______________

**HISTORY** £ Blurry Vision £ Glare £ Difficulty Viewing Television
£ Difficulty Seeing Traffic/Road Signs £ Difficulty Reading Fine Prints/Labels
£ Impaired Depth Perception £ Difficulty Recognizing Faces
Other______________________________________ Tensions $T_A$ ______________

**OCULAR EXAM**

Visual Acuity: 20/__________________OD 20/__________________OS

Glare Acuity: 20/__________________OD 20/__________________OS
(If Applicable)

**SLE** £ Immature Cataract £ PSC £ Nuclear Sclerosis
£ Mature £ Cortical £ Posterior Polar
£ Other: ____________________________________________________________

**Fundus** £ Normal £ Other ______________________________

**Ocular Meds/Dosage** ____________________________________________________________

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Allergies:________________________ Mental Status: ___________ Other: _______________

Diagnosis: ______________________________________________________________________

Plan: __________________________________________________________________________

Risk of Complication: *Explained to patient and documented*

**Post Operative Plan** – See patient postoperatively within 24 hours of surgery. Patient to receive postoperative instructions for care and precautions of the eye from the Surgery Center, which were adopted by the medical staff of Bergen-Passaic Cataract Surgery and Laser Center, Inc. A copy of these instructions is maintained in the policy and procedure manual of the Bergen-Passaic Cataract Surgery and Laser Center, Inc.

______________________________________________ ____________ ____________ £ AM £ PM
Surgeon Signature Date Time